ats

Standard Form 88
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, Merton Roger	Special Agent	
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
1015 2nd Ave. FBI, Seattle, Wash.	Annual	3-20-58

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
Male	Cauc.	3½	7	Justice Dept.	SEATTLE, WASH.

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
21 July 1920	Wisconsin	

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
USNMS SEATTLE, WASH.	

17. RATING OR SPECIALTY — TIME IN THIS CAPACITY: TOTAL — LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	ABNORMAL	(Check each item in appropriate column; enter "N. E." if not evaluated)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
	X	21. MOUTH AND THROAT
X		22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)
X		23. DRUMS (Perforation)
X		24. EYES—GENERAL (Visual acuity and refraction under items 59, 60, and 61)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (Equality and reaction)
X		27. OCULAR MOTILITY (Associated parallel movements. nystagmus)
X		28. LUNGS AND CHEST (Include breasts)
X		29. HEART (Thrust, size, rhythm, sounds)
X		30. VASCULAR SYSTEM (Varicosities, etc.)
X		31. ABDOMEN AND VISCERA (Include hernia)
X		32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate if indicated)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (Strength, range of motion)
X		36. FEET
X		37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)
X		38. SPINE, OTHER MUSCULOSKELETAL
X		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (Equilibrium tests under item 72)
X		42. PSYCHIATRIC (Specify any personality deviation)
Females only		(Check how done)
		43. PELVIC ☐ VAGINAL ☐ RECTAL

NOTES.—Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)

RECORDED - 11

ENCLOSURE

(Continue in item 73)

44. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively)

O.—Restorable teeth X.—Missing teeth (6×8).—Fixed bridge, brackets to include abutments
I.—Nonrestorable teeth XXX.—Replaced by dentures

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X		X		X	X						X			X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
		X	X	X									X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Class I
Type II
Qualified

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. 1.020			46. CHEST X-RAY (Place, date, film number, result)	47. SEROLOGY (Specify test used and result)
ALBUMIN	SUGAR	MICROSCOPIC		
Neg.	Neg.		0617 Neg. 3-20-58	Kahn Neg.

48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
Normal	"O" Neg.	None

THREE

10—62288-1

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: SLENDER / MEDIUM / HEAVY / OBESE	56. TEMP.
68"	156	Brown	Green	☐ / ☒ / ☐ / ☐	98.6

57. BLOOD PRESSURE (*Arm at heart level*) — 58. PULSE (*Arm at heart level*)

SITTING	SYS. 108 / DIAS. 82	RECUMBENT	SYS. 116 / DIAS. 90	STANDING (3 min.)	SYS. F B / DIAS.	SITTING	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN.
						80	100	80		

59. DISTANT VISION		60. REFRACTION		61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY APR 21 1 08 PM '58	S.	CX	5 CORR. TO 38 BY
LEFT 20/ 20	CORR. TO 20/	BY	S.	CX	5 CORR. TO 38 BY

62. HETEROPHORIA: (*Specify distance*) ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT LEFT	Passed. FaLant		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS	69. INTRAOCULAR TENSION

70. HEARING — RIGHT WV 15 /15 SV 15/15; LEFT WV 15 /15 SV 15/15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 3896	4000 4096	8000 8192	
RIGHT	15	15	-5	-5		45	50	
LEFT	10	5	-5	0		5	35	

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

21/ Tonsils and adenoids absent NCD

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

21. NCD

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

None

77. EXAMINEE (*Check*)
☒ IS ☐ IS NOT QUALIFIED FOR F.B.I. Annual

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

76. PHYSICAL PROFILE

P	U	L	H	E	S

PHYSICAL CATEGORY

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN: T. H. ARMSTRONG, CAPT, MC USN RET — SIGNATURE: T. H. Armstrong

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*): F. V. PANNO, LT, DC, USNR — SIGNATURE: F. V. Panno

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

U. S. GOVERNMENT PRINTING OFFICE 16—62288-1

ANDERSON, Merton R.

ATTACHMENT TO STANDARD FORM 88
(Revised July 21, 1952)

Report of Medical Examination

FOR INFORMATION AND GUIDANCE OF MEDICAL EXAMINER:

The following portions of the attached examination report form need not be completed:

2	67	
3	68	
11	69	
14	71	(unless other examination indicates desirable)
17		
62		
65	72	

Item 48, the electrocardiogram, is not required unless the examinee is over 35 years of age or unless other examination indicates such is desirable.

If the examinee is an applicant, the Chest X-ray and blood type and Rh factor (Items 46 and 49) are not necessary unless the facilities for affording same are readily available to the examiner.

FOR ALL EXAMINEES, WHETHER CLERICAL OR SPECIAL AGENT APPLICANTS OR EMPLOYEES:

The medical examiner should answer the following question:

Examinee Is qualified for strenuous physical
(is or is not)
exertion. (Designate which)

FOR ALL MALE EMPLOYEES OR APPLICANTS:

The medical examiner is requested to answer the following:

Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

None

If answer is "yes" please specify.

IT IS ESSENTIAL THAT ALL STATEMENTS IN ITEMS 59, 61 64 and 60 PERTAINING TO VISUAL ACUITY, COLOR VISION, AND HEARING BE COMPLETED IN DETAIL.

T.H. Armstrong
(Signature of Medical Examiner)
T.H. ARMSTRONG CAPT MC USN RET

20 Mar. 58
(Date)

ENCLOSURE

FD-277 (Rev. 3-13-58)
STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

TO : Director, FBI

DATE: 4-13-59

FROM: SAC, SEATTLE

ATTENTION: PERSONNEL SECTION

SUBJECT: SA MERTON R. ANDERSON
ANNUAL PHYSICAL EXAMINATION

- [ ] Remylet _____.
- [ ] Rebulet _____.
- [x] Re physical examination 3/25/59.
- [ ] Weight without clothing now is _____.
- [ ] Dental work was completed on _____.
- [ ] Vision has been corrected to _____.
- [ ] Chest X-ray results were negative.
- [ ] Personal physician advised he is qualified for strenuous physical exertion and the use of firearms.
- [ ] Attached are Bureau of Employees' Compensation forms _____.
- [x] Physical examination reports are enclosed. (with SF-89 and EKG)
- [ ] Employee is scheduled for physical examination on _____.
- [x] Employee has not reviewed and initialed his physical examination report.
- [ ] Employee returned to active duty _____.
- [ ] Employee's physical condition is _____.
- [ ] UACB he is being placed on limited duty.
- [ ] UACB he is being removed from limited duty.
- [x] Additional remarks relative to items listed above: Seattle copy of Medical Examination Report has been sent to Spokane Resident Agency for initialing by SA ANDERSON. EKG report & tracings taken on 3/20/58 and forwarded to Seattle by Bureau R/S 4/6/59 returned to Bureau herewith.

1 - Bureau (Encls. - 5) (AM)
1 - Seattle
/LM
(2)

9 - ENCLOSURE
7 - Phy. Effects
2 - Spokane

Routing Slip
FD-4 (Rev. 12-4-57)

Date 4/1/59

To

XXX Director
Att. Pers. Sec.

FILE # 67-5724

☐ SAC
☐ ASAC
☐ Supv.
☐ Agent
☐ SE
☐ CC
☐ Steno
☐ Clerk

Title SA MERTON R. ANDERSON
PHYSICAL CONDITION

ACTION DESIRED

- ☐ Acknowledge
- ☐ Assign ..... Reassign .....
- ☐ Bring file
- ☐ Call me
- ☐ Correct
- ☐ Deadline .....
- ☐ Deadline passed
- ☐ Delinquent
- ☐ Discontinue
- ☐ Expedite
- ☐ File
- ☐ Initial & return
- ☐ Leads need attention
- ☐ Open Case
- ☐ Return with explanation or notation as to action taken.
- ☐ Prepare lead cards
- ☐ Prepare tickler
- ☐ Recharge serials
- ☐ Return assignment card
- ☐ Return file
- ☐ Return serials
- ☐ Search and return
- ☐ See me
- ☐ Send Serials ..... to .....
- ☐ Submit new charge-out
- ☐ Submit report by .....
- ☐ Type

Captioned employee received his annual physical examination at U. S. Naval Facility, Sand Point, 3/25/59, and the doctor states his EKG reflected a definite abnormal tracing. For comparison purposes, the examining doctor would like to have his last two tracings. His local

SAC D. S. HOSTETTER

XXX See reverse side

Office SEATTLE

67-70

CC 4-3-87

CD-AL
FBI

APR 3 4 18 PM '54

file shows that he received tracings 3/20/57 and 3/20/58, both being normal.

Please expedite and the tracings will be returned after their use.

3-36 (Rev. 12-1-57)

4-6, 1958/9

___ ALBANY	___ HOUSTON	___ OKLAHOMA CITY
___ ALBUQUERQUE	___ INDIANAPOLIS	___ OMAHA
___ ANCHORAGE	___ JACKSONVILLE	___ PHILADELPHIA
___ ATLANTA	___ KANSAS CITY	___ PHOENIX
___ BALTIMORE	___ KNOXVILLE	___ PITTSBURGH
___ BIRMINGHAM	___ LITTLE ROCK	___ PORTLAND
___ BOSTON	___ LOS ANGELES	___ RICHMOND
___ BUFFALO	___ LOUISVILLE	___ SAINT LOUIS
___ BUTTE	___ MEMPHIS	___ SALT LAKE CITY
___ CHARLOTTE	___ MIAMI	___ SAN ANTONIO
___ CHICAGO	___ MILWAUKEE	___ SAN DIEGO
___ CINCINNATI	___ MINNEAPOLIS	___ SAN FRANCISCO
___ CLEVELAND	___ MOBILE	___ SAN JUAN
___ DALLAS	___ NEWARK	___ SAVANNAH
___ DENVER	___ NEW HAVEN	XX SEATTLE
___ DETROIT	___ NEW ORLEANS	___ SPRINGFIELD
___ EL PASO	___ NEW YORK CITY	___ WASHINGTON, D. C.
___ HONOLULU	___ NORFOLK	___ QUANTICO

MERTON R. ANDERSON
SPECIAL AGENT
PHYSICAL CONDITION

Re attached routing slip 4-1-59. Enclosed is the electrocardiographic report and tracings which were taken on 3-20-58. This should be returned to the Bureau with SA Anderson's current medical report. Bureau records do not contain the tracings which were taken on 3-20-57. However, as noted, the results of the latter was normal.

Enclosure

RWB/fk

J. P. MOHR

61-76

Standard Form 88
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

CWK

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, Merton Roger	SA	
4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
No. 5513 "F" st., Spokane, Wash.	Annual	3-25-59

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	Cauc.	3½	8	Justice	Seattle

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7-21-20	Wisc.	

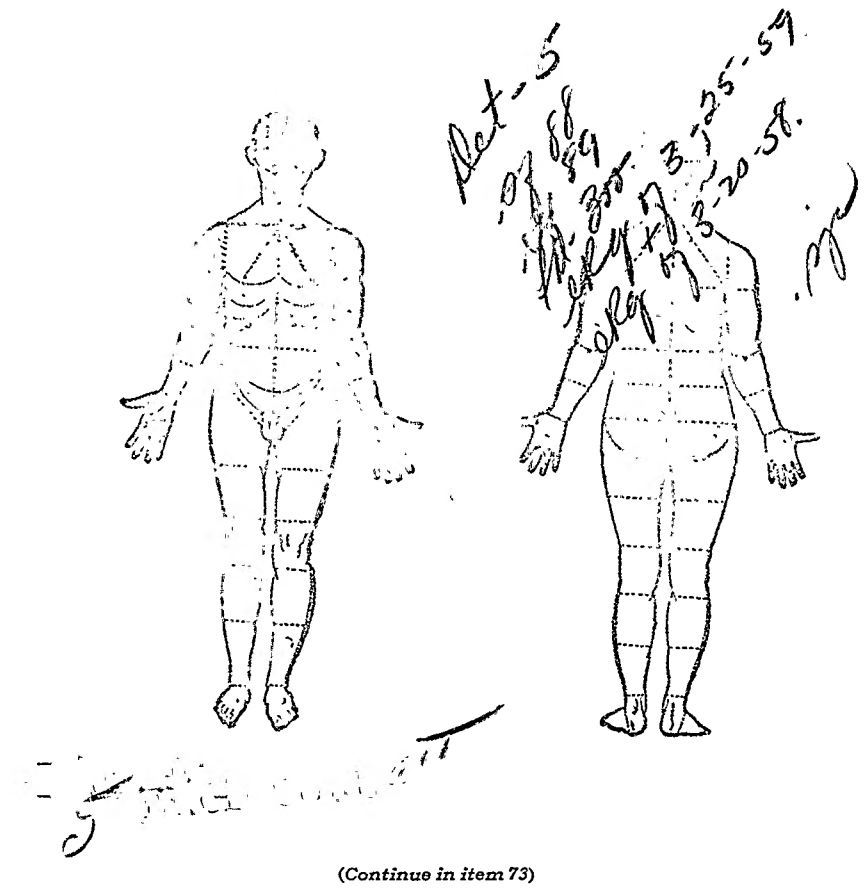
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
USNAS, SEATTLE, WASH.	

17. RATING OR SPECIALTY — TIME IN THIS CAPACITY: TOTAL — LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	ABNORMAL	(*Check each item in appropriate column; enter "N. E." if not evaluated*)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
X		21. MOUTH AND THROAT
X		22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)
X		23. DRUMS (*Perforation*)
X		24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60, and 61*)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (*Equality and reaction*)
X		27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)
X		28. LUNGS AND CHEST (*Include breasts*)
X		29. HEART (*Thrust, size, rhythm, sounds*)
X		30. VASCULAR SYSTEM (*Varicosities, etc.*)
X		31. ABDOMEN AND VISCERA (*Include hernia*)
X		32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate if indicated*)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (*Strength, range of motion*)
X		36. FEET
X		37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)
X		38. SPINE, OTHER MUSCULOSKELETAL
X		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (*Equilibrium tests under item 72*)
X		42. PSYCHIATRIC (*Specify any personality deviation*)
Females only		(*Check how done*) 43. PELVIC ☐ VAGINAL ☐ RECTAL

NOTES.—Describe every abnormality in detail. (Enter pertinent item number before each comment: continue in item 73 and use additional sheets if necessary.)



(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively*)
O.—*Restorable teeth* /.—*Nonrestorable teeth* X.—*Missing teeth* XXX.—*Replaced by dentures* (6×8).—*Fixed bridge, brackets to include abutments*

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X		X		X	X							X			X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Dent. Qual.
Type III, Class I
Part upper & part lower
Dentures.

70

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. 1.026			46. CHEST X-RAY (*Place, date, film number, result*)	47. SEROLOGY (*Specify test used and result*)
ALBUMIN	SUGAR	MICROSCOPIC		
Neg.	Neg.		#0671 Neg. 3-25-59	Kahn Neg.

48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
	"O" neg	None

16—62288-1

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: SLENDER / MEDIUM / HEAVY / OBESE	56. TEMP.
68"	154	Brown	Blue	☐ / ☒ / ☐ / ☐	98.6

57. BLOOD PRESSURE (*Arm at heart level*) — 58. PULSE (*Arm at heart level*)

	SITTING	RECUMBENT	STANDING (3 min.)	SITTING	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN.
SYS.	120			132				
DIAS.	80			78				80

59. DISTANT VISION		60. REFRACTION		61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S. CX	8/36	CORR. TO BY
LEFT 20/ 20	CORR. TO 20/	BY	S. CX	8/36	CORR. TO BY

62. HETEROPHORIA: (*Specify distance*) ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT LEFT	Passed FaLant		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS	69. INTRAOCULAR TENSION

70. HEARING — RIGHT WV 15 /15 SV 15 /15; LEFT WV /15 SV /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	8000 8192	
RIGHT	5	5	-5	-5		5	-10	
LEFT	10	5	-10	-5		10	0	

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

None

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

NCD

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

None

76. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)
☒ IS
☐ IS NOT QUALIFIED FOR Is phy qual for FBI Annual

PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN: C.R. HAMLIN, LT, MC, USN — SIGNATURE:

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE:

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*): F.V. PANNO, LT, DC, USN — SIGNATURE:

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

U. S. GOVERNMENT PRINTING OFFICE 16—62288-1

FD-300 (Rev. 5-21-58)

ATTACHMENT TO STANDARD FORM 88, REPORT OF MEDICAL EXAMINATION

FOR INFORMATION AND GUIDANCE OF MEDICAL EXAMINER

Name of Examinee: ANDERSON, Merton Roger
(Type or print) *Last* *First* *Middle*

The following portions of the attached examination report form need not be completed:

2	62
3	65
11	67
14	68
17	69
46	71
48	72
49	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible.

FOR ALL EXAMINEES, WHETHER CLERICAL OR SPECIAL AGENT APPLICANTS OR EMPLOYEES:

The medical examiner should answer the following question:

Examinee [X] is [ ] is not qualified for strenous physical exertion.

TO BE ANSWERED IN THE CASE OF ALL MALE EMPLOYEES AND MALE APPLICANTS:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?
[X] No [ ] Yes. If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?
[X] No [ ] Yes. If "yes" please specify defects. _____

67-70

Weights for Males

Height Feet-Inches	SMALL FRAME		MEDIUM FRAME		LARGE FRAME	
	Desirable	Maximum	Desirable	Maximum	Desirable	Maximum
5 4	121-131	143	129-139	152	136-148	162
5 5	124-134	146	132-142	155	140-152	166
5 6	128-138	151	136-146	160	144-157	172
5 7	131-142	155	140-151	165	148-161	176
5 8	135-146	160	144-155	170	152-165	181
5 9	139-150	164	148-159	174	156-170	186
5 10	143-154	168	152-163	178	160-175	192
5 11	147-159	174	156-168	184	164-180	197
6 0	152-164	179	161-173	189	169-185	203
6 1	158-170	186	166-179	196	174-191	209
6 2	163-175	192	171-184	201	179-197	216
6 3	168-180	197	176-189	207	184-202	221
6 4	174-186	204	182-195	214	190-208	228
6 5	180-191	209	188-201	220	196-214	234

3. Examinee's frame is ☐ small ☒ medium ☐ large

4. Considering above weight table the examinee's frame and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

5. Under proper medical supervision, examinee should ☐ lose _____ pounds

☐ gain _____ pounds

Remarks: _____

C.R. HAMLIN, LT, MC, USN

(Signature of Medical Examiner)

3-25-59

(Date)

FD-277 (Rev. 3-13-58)
STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

TO : Director, FBI

DATE: 5-11-60

FROM : SAC, SEATTLE

ATTENTION: PERSONNEL SECTION

SUBJECT: SA MERTON R. ANDERSON
ANNUAL PHYSICAL EXAMINATION

☐ Remylet _____ .

☐ Rebulet _____ .

☒ Re physical examination 3/30/60 .

☐ Weight without clothing now is _____ .

☐ Dental work was completed on _____ .

☐ Vision has been corrected to _____ .

☐ Chest X-ray results were negative.

☐ Personal physician advised he is qualified for strenuous physical exertion and the use of firearms.

☐ Attached are Bureau of Employees' Compensation forms _____ .

☒ Physical examination reports are enclosed. (with SF-89)

☐ Employee is scheduled for physical examination on _____ .

☐ Employee has reviewed and initialed his physical examination report.

☐ Employee returned to active duty _____ .

☐ Employee's physical condition is _____ .

☐ UACB he is being placed on limited duty.

☐ UACB he is being removed from limited duty.

☒ Additional remarks relative to items listed above: Seattle copy of medical report is being sent to Resident Agent ANDERSON for initialing.

1 - Bureau (Encls. - 2) (AM)
1 - Seattle
/LM
(2)

Standard Form 88
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, Merton Roger	Sp/Agent FBI	

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
N 5513 "F" St., Spokane, Wash.	Annual physical	3-30-60

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
Male	Caucasian	3½	9yrs	FBI	Seattle Office FBI

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7-21-20	Wisconsin Dells, Wisc.	(W) Lois Anderson, Same as # 4 above

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U.S. NAVSTA SEATTLE, WN	REL: PROTESTANT

17. RATING OR SPECIALTY — TIME IN THIS CAPACITY: TOTAL — LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	ABNORMAL	(*Check each item in appropriate column; enter "N. E." if not evaluated*)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
X		21. MOUTH AND THROAT
X		22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)
X		23. DRUMS (*Perforation*)
X		24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60, and 61*)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (*Equality and reaction*)
X		27. OCULAR MOTILITY (*Associated parallel movements. nystagmus*)
X		28. LUNGS AND CHEST (*Include breasts*)
X		29. HEART (*Thrust, size, rhythm, sounds*)
X		30. VASCULAR SYSTEM (*Varicosities, etc.*)
	X	31. ABDOMEN AND VISCERA (*Include hernia*)
X		32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate if indicated*)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (*Strength, range of motion*)
	X	36. FEET
X		37. LOWER EXTREMITIES (*Except feet*) (*Strength. range of motion*)
X		38. SPINE, OTHER MUSCULOSKELETAL
	X	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (*Equilibrium tests under item 72*)
X		42. PSYCHIATRIC (*Specify any personality deviation*)
Females only		(*Check how done*)
		43. PELVIC ☐ VAGINAL ☐ RECTAL

NOTES.—*Describe every abnormality in detail. (Enter pertinent item number before each comment: continue in item 73 and use additional sheets if necessary.)*

32. One external tag at 6:00. NCD.

36. Pronation of ankles-functional arches. NCD.

39. ANT: Sl½ Rt index finger, S¼ Lt thumb, S½ Lt knee.
POST: M Lt elbow, BMK LT scapular.

REC-19

REC-13

75

(Continue in item 73)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively*)

O.—*Restorable teeth* /.—*Nonrestorable teeth* X.—*Missing teeth* XXX.—*Replaced by dentures* (6 × 8).—*Fixed bridge, brackets to include abutments*

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X	O	X		X	X					X				X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Dentally qualified

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. 1.018			46. CHEST X-RAY (*Place, date, film number, result*)	47. SEROLOGY (*Specify test used and result*)
ALBUMIN	SUGAR	MICROSCOPIC	USNAVSTASEATTLE,WN. 3-30-60	
NEG	NEG	ESS NEG	#067680 Negative.	Negative.

48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
Within normal limits	"O" Negative	

MAY 30 1960

16—62288-1

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: SLENDER	MEDIUM	HEAVY	OBESE	56. TEMP.
68½	152	Brown	Blue	☐	☒	☐	☐	Normal

57. BLOOD PRESSURE (*Arm at heart level*) — MAY 17 3 07 PM '50

		SYS.	DIAS.
SITTING		110	72
RECUMBENT			
STANDING (*3 min.*)		C 118	82

58. PULSE (*Arm at heart level*)

SITTING	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN.
68	88	80		72

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

62. HETEROPHORIA: (*Specify distance*) ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT —— LEFT ——	Normal AOC 1940 Rev.		CORRECTED
66. FIELD OF VISION	**67. NIGHT VISION (*Test used and score*)**	**68. RED LENS**	**69. INTRAOCULAR TENSION**

70. HEARING

RIGHT WV 15 /15 SV 15 /15

LEFT WV 15 /15 SV 15 /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	8000 8192	
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

32. One external tag - at 6:00.
36. Pronation of ankles - functional arches. NCD.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)
☒ IS ☐ IS NOT QUALIFIED FOR Annual physical.

PHYSICAL CATEGORY

A	B	C	E

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN
F.D.LOVEJOY CAPT MC USN

SIGNATURE F.D.Lovejoy

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)
R.T.GARDNER LT DC USNR

SIGNATURE by Robert T. Burnett

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE: 1953—O-243413 16—62288-1

Standard Form 89
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON MERTON ROGER.	Special Agent FBI	
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
N. 5513 - P St. Spokane, Wash.	Annual	3/30/60

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE		10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	WHITE	3 1	7	FBI	SEATTLE OFFICE, FBI

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wis. Dells, Wis.	LOIS SANDERSON, WIFE, N. 5513 - P St. Spokane, Wash.

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U. S. NAVSTA SEATTLE, WN.	LUTHERAN

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	65	good		
MOTHER	64	"		
SPOUSE	34	"		
BROTHERS AND SISTERS				
	40	"		
CHILDREN	14	"		

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE:

YES	NO	(Check each item)	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
	X	HAD DIABETES	
X		HAD CANCER	Grandfather
	X	HAD KIDNEY TROUBLE	
X		HAD HEART TROUBLE	mother
	X	HAD STOMACH TROUBLE	
X		HAD RHEUMATISM *(Arthritis)*	mother
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY *(Fits)*	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS *(Night sweats)*		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS *(Inc. infantile)*
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE	X		CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART	X		BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
	X	EAR, NOSE OR THROAT TROUBLE	X		CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
(X)		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
X		HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER *(Check each item)*

X		WORN GLASSES		X	ATTEMPTED SUICIDE
	X	WORN AN ARTIFICIAL EYE	X		BEEN A SLEEP WALKER
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY: A. HAVE YOU EVER— B. COMPLETE THE FOLLOWING:

		BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
		HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS
		BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS
		HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
		HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU *(Check one)*
None	MONTHS N/A.	Special Agent FBI.	☒ RIGHT HANDED ☐ LEFT HANDED

16—62289-1

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
X		32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE ANY OPERATIONS? (*If yes, describe and give age at which occurred*)
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
X	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
X	X	35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
[illegible]	[illegible]

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
[illegible]	[illegible]	[illegible]	

U.S. GOVERNMENT PRINTING OFFICE 1950 O 746778 16—62289-1

FD-300 (Rev. 2-9-60)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (*Type or print*) ANDERSON, Merton Roger
Last *First* *Middle*

The following portions of the attached examination report form need not be completed:

2	62
3	65
4	67
9	68
11	69
14	72
17	76

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible.
Not done-Audiometer not available.

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee [X] is [ ] is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

[X] No [ ] Yes If "yes" please specify defects. _____

_____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

[X] No [ ] Yes If "yes" please specify defects. _____

_____

If examinee has defective vision, should he wear corrective glasses while operating a motor vehicle? [ ] Yes [X] No

67 - 7

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

3. Examinee's frame is ☐ small ☒ medium ☐ large

4. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

5. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

F.D. LOVEJOY CAPT MC USN
(Signature of Medical Examiner)

_____
(Date)

3-208 (Rev. 3-3-60)

SAC, SEATTLE 6/13/60

Director, FBI PERSONAL ATTENTION

MERTON R. ANDERSON
SPECIAL AGENT
PHYSICAL CONDITION

- ☐ Rebulet _____.
- ☒ Reurlet 5/25/60.
- ☐ Re Physical Examination _____.
- ☐ Submit Physical Examination Report.
- ☒ Advise Bureau re physical condition.
- ☐ Advise Bureau if dental work has been completed.
- ☐ Advise Bureau if vision has been corrected to 20/20.
- ☐ Submit results of ☐ chest x-ray, ☐ urinalysis, ☐ serology, immediately.
- ☐ Submit statement from doctor advising if Agent is qualified for strenuous physical exertion and the use of firearms.
- ☒ Submit Bureau of Employees' Compensation forms.
- ☐ Advise if medical bills submitted have been paid.
- ☐ Submit reply by _____.

pjs
(2)

Tolson
Mohr
Parsons
Belmont
Callahan
DeLoach
Malone
McGuire
Rosen
Tamm
Trotter
W.C. Sullivan
Tele. Room
Ingram
Gandy

MAILED 31
JUN 13 1960
COMM-FBI

REPLY: ATTENTION PERSONNEL SECTION

MAIL ROOM ☐ TELETYPE UNIT ☐

FD-277 (Rev. 3-13-58)
STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

TO : Director, FBI

DATE: 6-15-60

FROM : SAC, SEATTLE

ATTENTION: PERSONNEL SECTION

SUBJECT: MERTON R. ANDERSON
SPECIAL AGENT
PHYSICAL CONDITION

[x] Remylet 5-25-60 .

[x] Rebulet 6-13-60 .

[ ] Re physical examination _____ .

[ ] Weight without clothing now is _____ .

[ ] Dental work was completed on _____ .

[ ] Vision has been corrected to _____ .

[ ] Chest X-ray results were negative .

[ ] Personal physician advised he is qualified for strenuous physical exertion and the use of firearms .

[ ] Attached are Bureau of Employees' Compensation forms _____ .

[ ] Physical examination reports are enclosed.

[ ] Employee is scheduled for physical examination on _____ .

[ ] Employee has reviewed and initialed his physical examination report.

[ ] Employee returned to active duty _____ .

[x] Employee's physical condition is excellent .

[ ] UACB he is being placed on limited duty.

[ ] UACB he is being removed from limited duty.

[x] Additional remarks relative to items listed above: BEC forms submitted by SElet 6-14-60 with explanation.

(1) - Bureau (AM)
1 - Seattle
/LM
(2)

94

STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

TO : DIRECTOR, FBI

DATE: 5-25-60

FROM : SAC, SEATTLE

ATTENTION: PERSONNEL SECTION

SUBJECT: SA MERTON R. ANDERSON
PERSONNEL MATTER

On May 18, 1960, while conducting official investigation at the residence of Mrs. BETTY TURNER, N. 6621 Altamont, Spokane, Washington, in connection with a CGR case, SA ANDERSON was bitten by a neighborhood dog, suffering a puncture-type wound $\frac{1}{4}$-inch wide.

Dr. JOSEPH THALER, E. 2929 Wellesley, Spokane, Washington, a Government-approved physician, examined the wound, applied antiseptic and administered a shot of penicillin. The dog was picked up by the Humane Society of Spokane on 5/18/60 and placed under observation for 10 days. Should there be any developments, the Bureau will be advised immediately.

Forms CA-1 and CA-2 will be submitted as soon as the Statement of Medical Examiner has been completed on CA-2 and received in the Seattle Office.

(2) - Bureau (AM)
1 - Seattle

JEM:LM
(3)

Will follow in pending case

- 76

THREE

STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

TO : DIRECTOR, FBI

DATE: 6-14-60

FROM : SAC, SEATTLE

ATTENTION: PERSONNEL SECTION

SUBJECT: SA MERTON R. ANDERSON
PERSONNEL MATTER

ReSElet 5/25/60.

Enclosed is Form CA-1 in duplicate.

SA ANDERSON advises that Form CA-2 in duplicate was left at the office of Dr. JOSEPH THALER with the request that Dr. THALER complete the portion of these forms entitled "Statement of Government Medical Officer or Physician who first examined case" and return them to SA ANDERSON, since they required the signature of SAC MILNES before they could be forwarded to Washington.

Upon later contact by SA ANDERSON with SARAH DAUGHTERS, Dr. THALER's assistant, she advised that the two CA-2 forms had been completed by Dr. THALER and forwarded directly to the U. S. Department of Labor, Bureau of Employees Compensation, Washington 25, D. C. The Bureau is requested to advise if any further action should be taken by the Seattle Office in this regard.

2 - Bureau (Encls. - 2) (AM)
1 - Seattle
JEM:LM
(3)

3-451 (Rev. 5-16-60)

June 27, 1960

Bureau of Employees' Compensation
United States Department of Labor
General Accounting Office Building
Fourth and G Streets, Northwest
Washington 25, D. C.

Gentlemen:

Enclosed are compensation forms and/or other information (indicated below), relative to injuries or diseases incurred by the following-named employees of this Bureau: **Merton R. Anderson**

☒ CA-1 ☐ CA-2 ☐ ☐ ☐

OTHER INFORMATION

Compensation form CA-2 was forwarded to your agency by the physician who first examined Mr. Anderson, Dr. Joseph Thaler.

Very truly yours,

J. Edgar Hoover

John Edgar Hoover
Director

MAILED 8
JUN 27 1960
COMM-FBI

Tolson
Mohr
Parsons
Belmont
Callahan
DeLoach
Malone
McGuire
Rosen
Tamm
Trotter
W.C Sullivan
Tele Room
Ingram
Gandy

Enclosures (1)

1 - SAC, Seattle (Personal Attention)

See note, page 2

JWM (4)

MAIL ROOM ☒ TELETYPE UNIT ☐

62-103??

Bureau of Employees' Compensation
Washington 25, D. C.

NOTE: On 6-17-60 James W. Murray, Personnel Section, contacted Mr. Robert Farwig, Contact Representative, BEC. Mr. Murray related to Mr. Farwig that compensation forms CA-2 were forwarded directly to BEC by Dr. Thaler and he (Mr. Murray) requested that Farwig send one copy of form CA-2 to the Bureau. On 6-23-60 Mr. Farwig contacted Mr. Murray and advised that BEC had received forms CA-2 and that copy of same would be sent to the Bureau. On 6-24-60 form CA-2 was received.

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

Federal Employees' Compensation Act

This notice should be submitted to the immediate superior by an injured civil employee of the Federal Government, or by someone on his behalf, within 48 hours after the injury. Notice may be given either personally or by mail. It should be retained by the official superior unless the injury causes disability for work beyond the day or shift when injury occurred, or results in any charge against the Bureau for medical expense, when it should be forwarded to the U. S. DEPARTMENT OF LABOR, Bureau of Employees' Compensation, together with the official superior's report of injury, Form C. A. 2. Before compensation is paid, written claim on Form C. A. 4 must be submitted to the Bureau.

Date of this notice May 18, 1960

1. I hereby certify that I am employed as a Special Agent (Occupation)
at the Federal Bureau of Investigation Office, Spokane, Washington (Place of employment)
and on Wednesday (Day of week), May 18 (Date), 1960, at about 11:40 A (Hour, a. m. or p. m.) m.
I was injured in the performance of my duties at N. 6621 Altamont St., Spokane, Wash. (Location where injury occurred)

2. Cause of injury Small cocker type dog resented my entry into yard; made two attempts to bite and was warded off. While my attention was directed to occupant of house, dog made successful attempt and bit left leg. (Describe as best you can how and why injury occurred)

3. Nature of injury Puncture type wound, ¼" wide on inside calf of left leg (Name part of body affected—fractured left leg, bruised right thumb, etc.)

4. Names of witnesses to injury Mrs. Betty Turner, N. 6621 Altamont, Spokane, Washington

5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when

This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me.

Name Merton R. Anderson
Merton R. Anderson
Address N. 5513 "F" Street (Street and number)
Spokane (City or town) Washington (State)

C. A. 1
Revised October 23, 1952

U. S. GOVERNMENT PRINTING OFFICE, 16—45868-5

PLEASE DO NOT MUTILATE THESE FORMS IN ANY WAY.
(Merton R. Anderson)

Bulet 6-27-60 to
BEC encls. CA-1---
JWM

24

OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, Washington 25, D. C., as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department of Justice (War, Navy, etc.) 2. Bureau or office Federal Bureau of Investigation (Engineer, Navigation, etc.)
3. Place of employment FBI Office (Arsenal, navy yard, etc.), Spokane (City), Washington (State)
4. Reporting office Seattle, Washington (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred J. E. MILNES, Agent in Charge

The injured employee

6. Name of injured employee Merton R. Anderson (Give first name in full) 7. Age 39 8. Sex Male 9. Race White
10. Home address N. 5513 Ft. St. (Street and number), Spokane (City or town), Wash. (State)
11. Occupation and division Special Agent, FBI, Seattle Division (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? Yes If not, what work?
13. Total length of service with the Government as a civilian? 9 years
14. How long at present work in this establishment? 5 years
15. Dates of other injuries
16. Rate of pay on date of injury, $ 7270 per annum { and subsistence valued at $ per ; and quarters valued at $ per
17. Employee begins work at 8:15 A. m. (Hour, a. m. or p. m.) 18. Regular day's work ends 5:00 P. m. (Hour, a. m. or p. m.)
19. Hours worked per day 8 plus unscheduled overtime 20. Days paid per week Five

The injury

21. Place where injury occurred N. 6621 Altamont St., Spokane, Washington (Give exact location, as name or number of building and division, etc.)
22. Date of injury 5/18/, 1960; day of week Wednesday; hour of day about 11:40 A. m. (a. m. or p. m.)
23. Date employee stopped work 5/18, 1960; day of week Wednesday; hour of day 11:40 A. m. (a. m. or p. m.)
24. Date employee's pay stopped , 19; day of week ; hour of day m. (a. m. or p. m.)
25. Has employee returned to work? Yes, on 5/18/60 at 12:50 P.M. (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave
(b) Sick leave Yes for 2 hours on 5/18/60 (Give exact dates) (Give exact dates)
(c) Any other reason (Give exact dates)
27. Describe in full how injury occurred Small cocker type dog resented my entry into yard; made two attempts to bite and was warded off. While my attention was directed to occupant of house, dog made successful attempt and bit left leg
28. State part of body injured and nature and extent of injury Puncture type wound, 1/4" wide on inside calf of left leg
29. Did injury cause loss of any member or part of member? No If so, describe exactly
30. Was employee injured while in performance of duty? Yes If not, or in doubt, give detailed statement
31. Was injury caused by:
(a) Willful misconduct of the employee? no (b) Intention of employee to bring about injury or death of himself or another? no (c) Employee's intoxication? no
(If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)
32. Was written notice of injury given within 48 hours? Yes If not, did immediate superior have actual knowledge of injury?
(Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)
33. Names and addresses of witnesses to injury Mrs. Betty Turner, [redacted] b6 b7C [redacted]
(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)
34. Was injury caused by a third party other than a Government employee or agency? no If so, has employee been instructed in procedure under the Bureau's regulations?
(A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case Dr. Joseph Thaler, E. 2929 Wellesley, Spokane, Wash.
36. How soon after injury? Within one hour
37. To what hospital sent? None-treated at physicians office Location
38. Name and address of physician now attending case Dr. Joseph Thaler

Signed this 1st day of June, 1960 Joseph Thaler MD (Signature of reporting officer)
at Spokane, Wash. Designated Physician (Title)

C. A. 2
Revised April 15, 1953
16—6027-5

(OVER)

REC JUN 7 1960

Note that Dr. signed CA-2, however, inasmuch as Dr. sent his [illegible] deemed necessary to have SAC sign CA-2. JW

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

When I answered a knock on the door of my residence at N. 6621 Altamont, Spokane, Wash. about 11:30 A.M. on May 18, 1960, a man introduced himself to me as Agent Anderson of the FBI. A brown dog which has been staying at my place for about three weeks leaped at Mr. Anderson's leg and it looked like the dog bit him. I tried to call off the dog and finally succeeded. As Mr. Anderson left the dog again snapped at him, so I put my foot on the dog's head to hold him while Mr. Anderson left. The dog is a stray which came here and I have not fed him, and he does not belong to me.

Signed this 19th day of May, 1960

Mrs Betty Turner
(Signature of witness)

Signed this ____ day of ____, 19____

(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that Herton R. ANDERSON (Name of employee) was given first-aid treatment, or examined, on May 18, 1960, at 11:45am, and was not (Was or was not) disabled for work. Probable length of disability will be none In my opinion disability --- (Was or was not) due to injury on ----, 19____

Nature of injury as found on examination Dog bite left leg.

Hospitalized no Will return for further treatment no

Discharged yes, May 18, 1960 Other disposition none

Remarks ----

Signed this 1 day of June, 1960

at Spokane, Washington

Joseph Thaler
(Signature of medical officer)

Designated physician.
(Title)

U. S. GOVERNMENT PRINTING OFFICE 16—6027

FD-277 (Rev. 3-13-58)
STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

TO : Director, FBI DATE: 4/7/61

FROM : SAC, SEATTLE ATTENTION: PERSONNEL SECTION

SUBJECT: MERTON R. ANDERSON
REPORT OF MEDICAL EXAMINATION

☐ Remylet _____.

☐ Rebulet _____.

☒ Re physical examination 3/15/61.

☐ Weight without clothing now is _____.

☐ Dental work was completed on _____.

☐ Vision has been corrected to _____.

☐ Chest X-ray results were negative.

☐ Personal physician advised he is qualified for strenuous physical exertion and the use of firearms.

☐ Attached are Bureau of Employees' Compensation forms _____.

☒ Physical examination reports are enclosed. (SF-88, SF-89 and FD-300)

☐ Employee is scheduled for physical examination on _____.

☐ Employee has reviewed and initialed his physical examination report.

☐ Employee returned to active duty _____.

☐ Employee's physical condition is _____.

☐ UACB he is being placed on limited duty.

☐ UACB he is being removed from limited duty.

☐ Additional remarks relative to items listed above:

Seattle copy of Medical Report has been sent to Resident Agent ANDERSON for initialing.

APR 10 1961

1 - Bureau (Encl.-3)
1 - Seattle
JEM:eon
(2)

3 ENCLOSURE

67-NOT RECORDED

THREE

Standard Form 88
(Rev. June 1956)

REPORT OF MEDICAL EXAMINATION

gmc

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, Merton Roger	FBI Agent	

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
N5513 "F" St. Spokane, Washington	Annual	15 March 1961

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc.	3½yrs.	10yrs.	FBI	Spokane, Washington

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
21 July 20	Wis. Dells, Wisconson	(W) Lois S. ANDERSON Same as #4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
USNAS SEATTLE, WASHINGTON	RELIGION: Protestant

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
X	18. HEAD, FACE, NECK, AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
X	23. DRUMS (*Perforation*)	
X	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
X	25. OPHTHALMOSCOPIC	
X	26. PUPILS (*Equality and reaction*)	
X	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
X	28. LUNGS AND CHEST (*Include breasts*)	
X	29. HEART (*Thrust, size, rhythm, sounds*)	
X	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	X
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	X
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (*Strength, range of motion*)	
X	36. FEET	
X	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
X	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
X	40. SKIN, LYMPHATICS	
X	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
X	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

ENCLOSURE 17

67- [illegible] - 84
Searched ..... Numbered ....
4 APR 12 196[illegible]

REC-131

THREE

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth* I—*Nonrestorable teeth* X—*Missing teeth* XXX—*Replaced by dentures* (6X8)—*Fixed bridge, brackets to include abutments*

RIGHT																LEFT
X	X	3	X	5	X	X	8	9	10	11	12	X	14	15	X	
X	X	X	29	28	27	26	25	24	23	22	21	X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Type III
Class I
Qualified

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.020		46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN Neg.	D. MICROSCOPIC Ess. Neg.	#0964 Neg. 15 March 1961
C. SUGAR Neg.		

47. SEROLOGY (*Specify test used and result*)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL-Neg.	Normal- See #73	"O-"	

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
69"	153	Brown	Blue	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.6

RECD - ADMIN. DIV FBI APR 17 8 27 AM '61

57. BLOOD PRESSURE (*Arm at heart level*)

A. SITTING	SYS. 100 / DIAS. 60	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. 108 / DIAS. 64

58. PULSE (*Arm at heart level*)

A. SITTING	B. AFTER EXERCISE	C. MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
68	76	68		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 20 CORR. TO 20/	BY S. OX	8/36 CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. OX	8/36 CORR. TO BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT LEFT	AOC 1940 Revised 18/18		CORRECTED
66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV 15 /15 SV 15/15

LEFT WV 15 /15 SV 15/15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT	15	15	5	5	10	50	40	40
LEFT	15	10	0	0	10	15	10	35

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

#31 Lax left interior inguinal ring. NCD.

#32 Anal skin tag. NCD.

#48 EKG report: Occasional atrial premature beats. Occasional A-V nodal premature beats. Comparison to previous tracings in dicated, it any. EKG variant. NCD. (Noted for record purposes.)
Comparison to previous tracings on 4-6-61 indicate no change (WNL).

RECD - ADMIN. DIV FBI APR 12 9 30 AM '61

(*Use additional sheets if necessary*)

74 SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

#31 NCD.

#32 NCD.

#48 NCD.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

None

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR IS PHYS. QUAL. FOR ANNUAL FBI PHYSICAL.
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN
D. J. WILLIAMS, LT MC USNR
SIGNATURE D J Williams

80. TYPED OR PRINTED NAME OF PHYSICIAN
SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)
H. B. HAYNES, CAPT DC USN
SIGNATURE R B Haynes

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY
SIGNATURE
NUMBER OF ATTACHED SHEETS

U. S. GOVERNMENT PRINTING OFFICE: 1956—O-388206

Standard Form 89
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Anderson, Herton Roger	FBI Agent	
4. HOME ADDRESS *(Number, street or RFD, city or town, zone and State)*	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
N. 5513 "F" St., Spokane, Wash.	Annual Physical	3/15/61

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	White	3½	10	Federal Bureau of Investigation	Spokane Resident Agency

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wis. Dells, Wis.	Lois S. Anderson, wife, N. 5513 "F" St., Spokane, Wash.

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
NAS, Sandpoint, Seattle, Washington	

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*
Good

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	66	Good		
MOTHER	65	Good		
SPOUSE	34	Good		
BROTHERS AND SISTERS				
	41	Good		
CHILDREN	15	Good		

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* **OR HUSBAND OR WIFE:**

YES	NO	*(Check each item)*	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
	X	HAD DIABETES	
	X	HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM *(Arthritis)*	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY *(Fits)*	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	*(Check each item)*	YES	NO	*(Check each item)*	YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS *(Night sweats)*		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS *(Inc. infantile)*
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
	X	EAR, NOSE OR THROAT TROUBLE	X		CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE	X		BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
X		HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER *(Check each item)*

X		WORN GLASSES		X	ATTEMPTED SUICIDE
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY: A. HAVE YOU EVER—

		BEEN PREGNANT
		HAD A VAGINAL DISCHARGE
		BEEN TREATED FOR A FEMALE DISORDER
		HAD PAINFUL MENSTRUATION
		HAD IRREGULAR MENSTRUATION

B. COMPLETE THE FOLLOWING:

	AGE AT ONSET OF MENSTRUATION
	INTERVAL BETWEEN PERIODS
	DURATION OF PERIODS
	DATE OF LAST PERIOD

QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU *(Check one)*
One	MONTHS 10 yrs.	Special Agent, FBI	☒ RIGHT HANDED ☐ LEFT HANDED

16—62289-1

ENCLOSURE

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.	
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS	
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)	
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?	
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)	
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)	
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)	
	X	32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*)	
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)	
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)	
XX		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)	Treated by Dr. Arthur M.Clark, Paulsen Bldg., Spokane, Wash. for running ears during 1960
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)	
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)	
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)	
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)	

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE: MERTON ROGER ANDERSON

SIGNATURE: Merton R. Anderson

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

20 - Running Ears - hx of being wax NCD
Cramps - several yrs ago while swimming NCD

35 - As Above NCD

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
D. J. WILLIAMS, LT, MC, USNR	15MAR61	D. J. Williams	

U. S. GOVERNMENT PRINTING OFFICE: 1959—O-74678 16—62289-1

FD-300 (Rev. 2-9-60)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (*Type or print*) ANDERSON, Merton Roger
Last *First* *Middle*

The following portions of the attached examination report form need not be completed:

2	62
3	65
4	67
9	68
11	69
14	72
17	76

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible.

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

If examinee has defective vision, should he wear corrective glasses while operating a motor vehicle? ☐ Yes ☐ No

ENCLOSURE

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

3. Examinee's frame is ☐ small ☒ medium ☐ large

4. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

5. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

Signature of Examinee D. J. Williams

(Signature of Medical Examiner)

D. J. WILLIAMS
LT, MC, USNR

15 - 61

(Date)

FD-277 (Rev. 5-9-61)
OPTIONAL FORM NO. 10

UNITED STATES GOVERNMENT

Memorandum

TO : Director, FBI

DATE: 4/25/62

FROM : SAC, SEATTLE

Attention: Personnel Section

SUBJECT: SA MERTON R. ANDERSON
REPORT OF MEDICAL EXAMINATION

☐ Remylet _____.
☐ ReBulet _____.

☒ Re physical examination 3/28/62.
☐ Dental work was completed on _____.
☐ Vision has been corrected to _____.
☐ Results of ☐ chest X ray ☐ patch test ☐ urinalysis ☐ serology were negative.
☐ Enclosed physician's statement indicates he is qualified for strenuous physical exertion and use of firearms.
☐ Enclosed are ☐ paid ☐ unpaid medical bills.
☐ Attached are Bureau of Employees' Compensation forms _____.

☒ Physical examination reports are enclosed. (SF-88, SF-89 and FD-300)
☐ Employee is scheduled for physical examination on _____.
☐ Physical examination report has been reviewed and initialed.
☐ Employee has been instructed to wear corrective glasses while operating a motor vehicle.
☐ Employee returned to active duty _____.
☐ Employee's physical condition is _____.
☐ UACB he is being removed from limited duty.
☐ UACB he is being placed on limited duty.

Remarks:

Seattle copy of report has been forwarded to Resident Agent ANDERSON, Spokane, Washington, for initialing.

1 - Bureau (Encl.-3) (AM)
1 - Seattle
/eon
(2)

3 ENCLOSURES

1992 45

SERIALIZED RECORDED-6

THREE

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-32 (Rev.)

men

REPORT OF MEDICAL EXAMINATION

88-105

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, Merton Roger	SP/AG	
4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
N. 5513 "F" St. Spokane, Washington	ANNUAL	3-28-62

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
Male	Cauc	MILITARY 3y6m	CIVILIAN 11y	FBI	SEATTLE, WN.

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7-21-20	Wis. Dells, Wisconsin	(W) Lois J. ANDERSON Same as # 4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
USNAS SEATTLE, WASHINGTON	REL: PROT

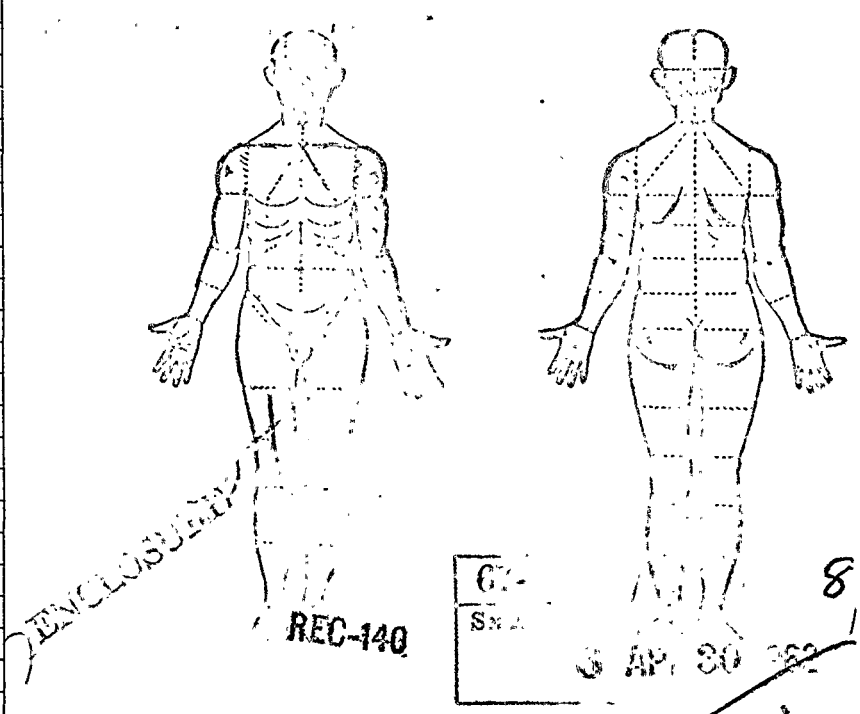
17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
X	18. HEAD, FACE, NECK AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
X	23. DRUMS (*Perforation*)	
X	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
X	25. OPHTHALMOSCOPIC	
X	26. PUPILS (*Equality and reaction*)	
X	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
X	28. LUNGS AND CHEST (*Include breasts*)	
X	29. HEART (*Thrust, size, rhythm, sounds*)	
X	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
X	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	X
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (*Strength, range of motion*)	
X	36. FEET	
X	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
X	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
X	40. SKIN, LYMPHATICS	
X	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
X	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

M & S NR



ENCLOSURE (1)

REC-140

6 SEP 30 1962

86

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth* /—*Nonrestorable teeth* X—*Missing teeth* XXX—*Replaced by dentures* (6 X 8)—*Fixed bridge, brackets to include abutments*

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X	O	O	O	O	X	O	O	O	O	O	O	O	O	O	
	X	O	O	O	O	O	O	O	O	O	O	O	XXX	XXX	XXX	O	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

DENT. QUAL.

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.020	46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN Neg.	D. MICROSCOPIC	#005241 Neg. 3-28-62 NAS SEATTLE, WN.
C. SUGAR Neg.	ESS. NEG.	

47. SEROLOGY (*Specify test used and result*)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL Neg. 3-28-62	wnl 3-28-62	O NEG.	

45

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
68 in	153	Brown	Gray	☐ SLENDER ☐ MEDIUM X ☐ HEAVY ☐ OBESE	Normal

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A. SITTING	SYS. 116 DIAS. 74	B. RECUMBENT	SYS. DIAS.	C. STANDING (*3 min.*)	SYS. 106 DIAS. 76	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						72	88	72		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 20 CORR. TO 20/	BY S. OX	8/36 CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. OX	8/36 CORR. TO BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	Passed Falant		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING		71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV	15/15 SV 15/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	15/15 SV 15/15	RIGHT	20	10	5	5	5	45	30	65	
		LEFT	25	15	0	-5	5	5	10	25	

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

NCD

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

#32-Anal skin tag at 6 o'clock with sacrum at 12 o'clock. NCD

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

NONE

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR IS PHYS. QUAL. FOR ANNUAL FBI
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
D.J. WILLIAMS, LT MC USNR	D.J. Williams
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)	SIGNATURE
R.B. HAYNES, CAPT DC USN	R.B. Haynes
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

Standard Form 89
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Anderson, Merton Roger	Special Agent	

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
N. 5513 "F" St., Spokane, Wash.	Annual	3/28/62

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	White	3½	11	FBI	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisl Dells, Wisc.	Lois I. Anderson, wife - same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Sandpoint NAS, Seattle, Wash.	

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (*Follow by description of past history, if complaint exists*)

Good

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	67	Good		
MOTHER	66	Good		
SPOUSE	34	Good		
BROTHERS	42	Good		
AND				
SISTERS				
CHILDREN	16	Good		

19. HAS ANY BLOOD RELATION (*Parent, brother, sister, other*) OR HUSBAND OR WIFE:

YES	NO	(*Check each item*)	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
	X	HAD DIABETES	
	X	HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM (*Arthritis*)	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY (*Fits*)	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW (*Place check at left of each item*)

YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS (*Night sweats*)		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS (*Inc. infantile*)
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
X		DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART	X		BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
	X	EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
	X	HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (*Check each item*)

X		WORN GLASSES		X	ATTEMPTED SUICIDE
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY: A. HAVE YOU EVER— B. COMPLETE THE FOLLOWING:

		BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
		HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS
		BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS
		HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
		HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU (*Check one*)
~~The~~ One	MONTHS 132	Special Agent	☒ RIGHT HANDED ☐ LEFT HANDED

16—62289-1

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D OTHER MEDICAL REASONS (*If yes, give reasons*)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
XX	~~X~~	32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE ANY OPERATIONS? (*If yes, describe and give age at which occurred*)
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)
	X	39 HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

Tonsilectomy - Military Service 1943
USAF

Bed rest [illegible]

Virus infection in inner ear caused dizziness. Treated by Dr. Arthur Clark, Spokane, Wash. 1961.

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R. Anderson

40. PHYSICIAN S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
D. J. WILLIAMS LT, MC, USNR	3-28-62		

U S GOVERNMENT PRINTING OFFICE 1950 O 74678 16—62289-1

FD-300 (Rev. 2-9-60)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) Merton (First) Roger (Middle)

The following portions of the attached examination report form need not be completed:

2	62
3	65
4	67
9	68
11	69
14	72
17	76

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible.

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

If examinee has defective vision, should he wear corrective glasses while operating a motor vehicle? ☐ Yes ☐ No

64-24141-1

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

3. Examinee's frame is ☐ small ☐ medium ☒ large

4. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

5. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

D. J. WILLIAMS
Capt, MC, USNR
(Signature of Medical Examiner)

3-28-62
(Date)

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-32 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-106

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1340 W. 6th St., Los Angeles, Calif.	ANNUAL PHYSICAL	3/28/63

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	12	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisconsin	Wife - Lois Anderson, ~~same address~~

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION	
U S PUBLIC HEALTH, San Pedro, Calif.	***	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

(*Continue in item 73*)

67-24145[illegible]-90
Searched 24
6 MAY 15 1963
ENCLOSURE
REC-143
THREE

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth*
/—*Nonrestorable teeth*
X—*Missing teeth*
XXX—*Replaced by dentures*
(6 X 8)—*Fixed bridge, brackets to include abutments*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT	X	X		(X	0	X	X)					0	X			X	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										(X	X	X)	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.020
B. ALBUMIN neg.
C. SUGAR neg.
D. MICROSCOPIC 0-1 WBC/HPF, amorphous material.

46. CHEST X-RAY (*Place, date, film number and result*)
USPHS, SAN PEDRO, CALIF., #7619,
3-28-63: Normal.

47. SEROLOGY (*Specify test used and result*)
VDRL: Non-reactive

48. EKG
Normal

49. BLOOD TYPE AND RH FACTOR
Not required

50. OTHER TESTS
HEMATOLOGY: WBC-8,600, Hemoglobin-16.7gms.

MAY 22 1963

MRA

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD; (Check one) SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
5' 8"	160 lbs.	Brown	Blue			x		98.6

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. 128/ DIAS. 78	B. RECUMBENT	SYS. DIAS.	C. STANDING (3 min.)	SYS. DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						64	96	72		

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S.	OX	R=J1 CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S.	OX	L=J1 CORR. TO	BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	ISHIHARA – OK.		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING		71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15	SV 20 /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15	SV 20 /15	RIGHT									
		LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR duty.

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN
SPENCER FOREMAN, MD., SAS (R)

SIGNATURE Spencer Foreman MD

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)
GRESHAM T. FARRAR, DMD.; Dental Surgeon

SIGNATURE Gresham T. Farrar DS.

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

GOVERNMENT PRINTING OFFICE : 1961 612730

Standard Form 89
(Rev. Aug. 1950)
Promulgated by
Bureau of the Budget
Circular A-24

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	* * *
4. HOME ADDRESS *(Number, street or RFD, city or town, zone and State)*	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
1340 W. 6th St., Los Angeles, Calif.	ANNUAL PHYSICAL	3/28/63

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE (MILITARY / CIVILIAN)	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
Male	Cauc	3½ / 12	F B I	* * *

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson, same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	* * *

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*

Good

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	69	good		
MOTHER	68	good		
SPOUSE	36	good		
BROTHERS AND SISTERS	43	good		
	none			
CHILDREN				
Son	17	good		

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE:

YES	NO	(Check each item)	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
	X	HAD DIABETES	
X		HAD CANCER	grandfather
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM *(Arthritis)*	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY *(Fits)*	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS *(Night sweats)*		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS *(Inc. infantile)*
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
		HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER *(Check each item)*

X		WORN GLASSES		X	ATTEMPTED SUICIDE
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY: A. HAVE YOU EVER—

	BEEN PREGNANT
	HAD A VAGINAL DISCHARGE
	BEEN TREATED FOR A FEMALE DISORDER
	HAD PAINFUL MENSTRUATION
	HAD IRREGULAR MENSTRUATION

B. COMPLETE THE FOLLOWING:

AGE AT ONSET OF MENSTRUATION
INTERVAL BETWEEN PERIODS
DURATION OF PERIODS
DATE OF LAST PERIOD
QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU *(Check one)*
One	MONTHS three years	Special Agent	☒ RIGHT HANDED ☐ LEFT HANDED

16—62239-1

67-241 HQ-1-70

MRG

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
X		32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*) Tonsilectomy - 22 yrs. in USAF
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*) By HAROLD OWENS, M.D. 2010 Wilshire Blvd. L.A.Calif. for ear fungus.-cured.
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Merton R. Anderson	Merton R. Anderson

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
SPENCER FOREMAN, MD., SAC[illegible]R)	3-28-63	[illegible]	

16—62389-1 ☆ U. S. GOVERNMENT PRINTING OFFICE

FD-300 (Rev. 10-10-62)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	14	68
3	17	69
4	62	72
9	65	76
11	67	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in each ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

ENCLOSURE 67-241451-90

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

3. Examinee's frame is ☐ small ☐ medium ☑ large

4. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☑ Satisfactory ☐ Excessive ☐ Deficient

5. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____
(Signature of Medical Examiner)

3-28-63
(Date)

Form 2413
(June 1943)

UNITED STATES CIVIL SERVICE COMMISSION

CERTIFICATE OF MEDICAL EXAMINATION

Applicant must fill in dotted line below to heavy line

MERTON R. ANDERSON (Name) — BOX 68 HONDO TEXAS (Post-office address)

Male (Sex) — July 21 1920 (Date of birth) — Typing (Title of examination taken)

Dept of Justice FBI (Department and bureau in which you are to be employed) — (City or town in which you are to be employed)

1. Have you any physical defect or disease or disability whatsoever? Yes

2. If answer is "yes" give details slight astigmatism corrected by glasses

Doctor: ALL QUESTIONS MUST BE ANSWERED

67 1/2 inches. (Height, without shoes) — 142 pounds. (Weight, in clothing) — 138 pounds. (Weight, without clothing) Males, with and without clothing; females, clothed, but without wrap or hat.

Items checked (V) were examined and found normal. Deviations from normal are noted under "Remarks." (See instructions on reverse side, numbered to correspond with items below.)

1. Eyes: Distant vision (Snellen): Without glasses: Right: 20/ to Left: 20/ With glasses if worn: Right: 20/ Left: 20/

Near vision: What is the longest and the shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

and employees in the Federal classified service as may be requested by the Civil Service Commission or its authorized representative.
This order will supplement the Executive orders of May 29 and June 18, 1923 (Executive order, September 4, 1924). (Jaeger No. 2)

	Without glasses:	With glasses, if used:
R.	8 in. to 15 in.	R. ____ in. to ____ in.
L.	8 in. to 15 in.	L. ____ in. to ____ in.

Evidence of disease or injury: Right none Left none

Color vision: Is color vision normal when Ishihara or other color plate test is used? Yes

If not, can applicant pass lantern, yarn, or other comparable test? ____

2. Ears: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.) Ordinary conversation: Right ear 20/20 ft. Left ear 20/20 ft. Evidence of disease or injury: Right ear none Left ear none

3. Nose, sinus disease, etc. normal

4. Mouth and throat tonsils absent

5. Gastro-intestinal normal

6. Metabolic disorders none 6a. Thyroid (especially in women) normal 6b. Diabetes Mellitus no

7. Heart and blood vessels normal

Blood pressure: Mm. Hg. systolic 110 Mm. Hg. diastolic 70

Is organic heart disease present? no If organic heart disease is present, is it fully compensated? ____

8. Lungs: Right normal Left normal

History of tuberculosis? no If so, has the disease been arrested for at least 1 year? ____

If there is a history of tuberculosis, is any type of collapse therapy being received at present? (If so, give full details under remarks.) ____

5a. History of peptic ulcer: If history is present, is ulcer: Active? ____ Quiescent? ____ Healed? ____ How long? ____ Has an X-ray study been made? ____

9. Hernia no
(If present, name variety: Inguinal, ventral, femoral, post-operative, etc. Read definition on reverse before answering)

If present, is it supported by a well-fitting truss? ____

10. Varicose veins no (If present, state location and degree)

Varicocele (see note 10 on reverse side) no

11. Feet: Is flat foot present? no (See note 11 on reverse side) Degree of impairment of function ____ (None, slight, moderate, severe)

12. Deformities, atrophies, and other abnormalities, diseases, or defects not included above ____

13. Scars of serious injury or disease no

14. Nervous system: (a) (see note 14 on reverse side) normal

(b) Is there any history of a "nervous break-down"? no

(c) If hospitalized, give name of hospital, location, and date ____

15. (a) Evidence or history of venereal disease? no (b) Urinalysis (see reverse side) ____

16. Obtain from applicant statement of disabilities, past and present, give diagnosis and your comments under "Remarks."

17. Does Veterans Administration recognize service-connected disability in this case? no (Yes or no) If "yes," cover in your comments.

18. Has examinee ever received disability retirement from U. S. Civil Service Commission? no (Yes or no)

16—1066-3

This certificate is to be returned to the official requesting the examination

[OVER]

12/3/47

The aim of the Executive order of September 4, 1924, under which this examination is made, is to obtain information as to the physical condition of appointees to the classified civil service with a view to promoting efficiency and minimizing accidents and claims under United States employees' compensation laws.

Notes for Examining Physician

WEIGHT.—Males, without clothing, and also in ordinary clothing without overcoat or hat (weigh twice); females, clothed, but without wrap or hat.

HEIGHT.—Without boots or shoes; observe that no appliances are used to increase.

The examination should include the following observations:

1. **Eyes.**—Ptosis; discharge; corneal scar; pterygium. In recording distant vision consider 20 feet as normal and report all vision as a fraction with 20 feet as numerator and the smallest type read at 20 feet as denominator. If glasses are used, record for each eye the finding with and without glasses. Near vision must be reported. In testing vision without glasses the applicant or appointee should be instructed to *remove the glasses at least one-half hour before testing uncorrected vision.*

2. **Ears.**—Evidence of middle ear or mastoid disease; condition of drums; discharge. In recording hearing, record 20 feet as normal distance for conversational voice and record deviation from normal as fraction with 20 as denominator and actual distance as numerator.

3. **Nose.**—Ability to blow through each nostril. If free, a speculum examination would not be indicated.

4. **Mouth and throat.**—Missing teeth, pyorrhea; tonsils, hypertrophy or disease.

5. **Gastro-intestinal.**—Ulcers, inflammations, etc.

6. **Thyroid.**—Presence of tumor in neck and tremor, exophthalmos; nervous high-strung disposition, especially in women.

7. **Heart.**—Murmurs. State whether functional or organic. If valvular disease exists, state whether or not it is fully compensated. Arteriosclerosis.

8. **Lungs.**—It is necessary that the auscultatory cough be used. If tuberculosis is present, state whether active or arrested; if arrested, state your opinion as to how long it has been quiescent. Sputum to be examined for tubercle bacilli in all suspected cases.

9. **Hernia.**—Give details as to size, location, etc., and whether well-fitting truss is worn. Inguinal hernia exists when ring is enlarged and on coughing visceral impulse is felt which follows the finger on withdrawal.

10. **Varicocele.**—If varicocele is present, state approximate size—e. g., size of walnut, lemon, etc.

11. Flat foot of such a nature as to incapacitate or become aggravated by work or be alleged later to have been caused by accident or occupation. By "flat foot," as used in this form, is meant a *weak* foot with impaired function, the term being equivalent to "fallen or misplaced arch," an abnormal condition. Impairment of function is the point to be noted. An anatomically flat foot, but strong, is not disqualifying. Function should be tested by requiring the examinee to raise his weight several times on his toes and to jump as far as possible, alighting on his toes.

12 and 13. Scars, deformities, atrophies, and paralyses should be noted, but it is not important that small insignificant scars or blemishes which might be referred to as marks of identification be recorded.

14. This entry should include symptoms and full history of any mental or nervous abnormality.

15. Urinalysis to be made in case of persons over 40, and in all cases where arteriosclerosis, nephritis, or diabetes is suspected, and when obesity is found on examination.

Record of urinalysis, if made: Sp. gr. _____ Albumen _____ Sugar _____ Casts _____

Blood serology test, if made: Result _____

If arrhythmia, bradycardia, or tachycardia is present, give pulse rate: Sitting _____ Immediately after exercise (unless contraindicated) _____ Two minutes after exercise _____ Cardiac reserve Good
(Good, fair, or poor)

I have found this applicant abnormal under the following headings: _____

In my opinion, applicant is capable of performing duties involving arduous physical exertion.
(Arduous, moderate, or light)

REMARKS: _____

(*Signature of applicant*) Merton R. Anderson
(This space to be filled in, as a matter of identification, by the applicant in own handwriting, and in ink, in the presence of the physician)

Houston Texas
(Place of examination—City and State)

November 17 1947
(Date of examination)

The examining physician must be a duly licensed doctor of medicine (M. D.)

R. O. Lawrence, M. D.
(Signature of examining physician)

(If in Federal medical service, give title and branch)

Full time? _____ Part time? _____ Fee paid? _____

The personnel officer should fill in the blanks below before sending this form to the Commission for action

To be appointed in _____ (Department) _____ (Bureau)

Title of position _____

Type of appointment (check): ☐ Original appointment ☐ Transfer ☐ Reinstatement ☐ Classification

Number of certificate upon which applicant's name appears (to be given in case of original appointment) _____

U. S. GOVERNMENT PRINTING OFFICE 16—1066-3

CC-815

FEDERAL BUREAU OF INVESTIGATION
Division Three

Date 12/3 1947

____Director	____Mr. H. L. Edwards
____Mr. Tolson	____Mr. W. E. Clark
____Mr. E. A. Tamm	____Mr. C. R. Davidson
____Mr. Glavin	____Mr. J. E. Edwards
____Mr. H. H. Clegg	____Mr. D. Norman
____Mr. Harbo	____Mr. C. L. Trotter
____Mr. Ladd	____Mr. _____
____Mr. Nichols	Room_____
____Mr. Rosen	____Miss_____
____Mr. Tracy	Room_____
____Mr. Mohr	____Miss Eitel
____Mr. Hince	____Miss Guigon
____Mr. M. A. Jones	____Miss Hayes
____Miss Gandy	____Mrs. Jacobs
____Mr. Nease	____Mrs. Keefe
____Mr. O'Connor	____Miss Kubalak
____Mr. Pennington	____Mrs. Skilling
____Mr. Q. Tamm	____Mrs. Taisey
____Mr. Callahan	____Mrs. Wackerman
____Mr. Gauthier	____Mrs. Wood
____Mr. Gresham	
____Mr. Gunsser	____Please Handle
____Mr. W. C. Jackson	____Note and Return
____Mr. Newman	____Phone Me
____Mr. Renneberger	____See Me
____Mr. Travers	
____Miss Day	____Mrs. Fern Edwards
____Mrs. Brown	____Miss Morse
____Mrs. Skillman	____Mrs. Shoemaker
____Miss Weber	
	____Washington Field
____Personnel Records	____Send File
____Mechanical Section	
____Supply Section	

Vision given is appar. with glasses.

Heath Newcomer
Personnel Unit
(Room 7204)

The following is the record of FBI number

CONTRIBUTOR OF FINGERPRINTS	NAME AND NUMBER	ARR RE

* Represents notations unsupported by finger[redacted] in FBI files.

NOTICE: THIS RECORD IS FURNI

Standard Form 88
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON ROGER	CLERK - San Antonio Div.	

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
Hondo Texas	Application	2/20/51

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	W	3½ yrs		air corps	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
July 21-20	Wis. Dells, Wis.	Lois Anderson - wife

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Dr R W Landers Hondo Texas	

17. RATING OR SPECIALTY — TIME IN THIS CAPACITY: TOTAL — LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	ABNORMAL	(*Check each item in appropriate column; enter "N. E." if not evaluated*)
✓		18. HEAD, FACE, NECK, AND SCALP
✓		19. NOSE
✓		20. SINUSES
✓		21. MOUTH AND THROAT
✓		22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)
✓		23. DRUMS (*Perforation*)
✓		24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60, and 61*)
✓		25. OPHTHALMOSCOPIC
✓		26. PUPILS (*Equality and reaction*)
✓		27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)
✓		28. LUNGS AND CHEST (*Include breasts*)
✓		29. HEART (*Thrust, size, rhythm, sounds*)
✓		30. VASCULAR SYSTEM (*Varicosities, etc.*)
✓		31. ABDOMEN AND VISCERA (*Include hernia*)
✓		32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate if indicated*)
✓		33. ENDOCRINE SYSTEM
✓		34. G-U SYSTEM
✓		35. UPPER EXTREMITIES (*Strength, range of motion*)
✓		36. FEET
✓		37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)
✓		38. SPINE, OTHER MUSCULOSKELETAL
✓		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
✓		40. SKIN, LYMPHATICS
✓		41. NEUROLOGIC (*Equilibrium tests under item 72*)
✓		42. PSYCHIATRIC (*Specify any personality deviation*)
Females only		(*Check how done*)
		43. PELVIC ☐ VAGINAL ☐ RECTAL

NOTES.—Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)

MAR 15 1951 2-71 4-51 21 51

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively*)

O.—*Restorable teeth* /.—*Nonrestorable teeth* X.—*Missing teeth* XXX.—*Replaced by dentures* (6 X 8).—*Fixed bridge, brackets to include abutments*

RIGHT																LEFT
	X	X	3	4	5	6	7	8	9	10	11	12	X	14	15	X	
	X	31	X	29	28	27	26	25	24	23	22	21	20	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. 1.028			46. CHEST X-RAY (*Place, date, film number, result*)	47. SEROLOGY (*Specify test used and result*)
ALBUMIN	SUGAR	MICROSCOPIC		Kline Exclusion - neg.
neg.	neg.	neg.		
48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS		

R.D. 3/6/51
Received in HQ.

16—62288-4

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE ☐	56. TEMP.
68	134	Blonde	Blue		98.2

57. BLOOD PRESSURE (*Arm at heart level*)

SITTING	SYS. 110 / DIAS. 70	RECUMBENT	SYS. 110 / DIAS. 70	STANDING (3 min.)	SYS. 110 / DIAS. 70	

58. PULSE (*Arm at heart level*)

SITTING	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN.
84	88	84	80	84

59. DISTANT VISION		60. REFRACTION		61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S. CX	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S. CX	CORR. TO	BY

62. HETEROPHORIA: (*Specify distance*) ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT Normal LEFT Normal	Colored Skein		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS	69. INTRAOCULAR TENSION
90° both eyes			

70. HEARING

RIGHT WV 15 /15 SV /15

LEFT WV 15 /15 SV /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	8000 8192	
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) **AND SIGNIFICANT OR INTERVAL HISTORY**

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

None

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

☒ IS ☐ IS NOT QUALIFIED FOR ardurous duty

PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
DR. R. W. LANDERS	R W Landers
80. TYPED OR PRINTED NAME OF PHYSICIAN	**SIGNATURE**
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)	**SIGNATURE**
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	**SIGNATURE** / **NUMBER OF ATTACHED SHEETS**

U. S. GOVERNMENT PRINTING OFFICE 16—62288-1

ATTACHMENT TO STANDARD FORM 88
(Revised August, 1950)

Report of Medical Examination

FOR INFORMATION AND GUIDANCE OF MEDICAL EXAMINER:

The following portions of the attached examination report form need not be completed:

2		62
3		65
11		67
14		68
17		69
48	(unless other examination indicates desirable)	71
49		72

Chest x-ray not necessary in absence of symptoms, unless examination being conducted at public health facility where chest x-ray is available.

FOR ALL APPLICANTS, WHETHER FOR CLERICAL OR SPECIAL AGENT POSITIONS:

Medical examiner should answer following question:

Applicant (examinee) ___is___ qualified for strenuous physical exertion. (Designate which)
is, is not

FOR ALL MALE APPLICANTS:

Medical examiner is requested to answer following:

Does applicant (examinee) have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms:

No

If answer is "yes" please specify.

R. E. Saunders
(Signature of Medical Examiner)

Feb 20 1951
(Date)

: SAC, San Antonio (Your file)

September 11, 1952

: Director, FBI

~~PERSONAL AND CONFIDENTIAL~~

MERTON R. ANDERSON
Clerk

( ) Rebulet _____.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) The Bureau is in receipt of Compensation Forms C. A. 1; however, it is requested that form C. A. 2 also be executed and forwarded to the Bureau as soon as possible.

JVB:cnm

Tolson
Ladd
Nichols
Belmont
Clegg
Glavin
Harbo
Rosen
Tracy
Laughlin
Mohr
Tele. Rm.
Holloman
Candy

: SAC, San Antonio (Your file)

: Director, FBI

October 1, 1952

~~PERSONAL AND CONFIDENTIAL~~

MERTON R. ANDERSON
Clerk

( ) Rebulet _____.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) ~~Submit Compensation Form C.A. 2.~~

_____

_____

Tolson
Ladd
Nichols
Belmont
Clegg
Glavin
Harbo
Rosen
Tracy
Laughlin
Mohr
Tele. Rm.
Holloman
Gandy

: SAC, San Antonio (Your file)

October 3, 1952

: Director, FBI

MERTON R. ANDERSON
Clerk

(X) Re attached form.
( ) Rebulet _____.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) ~~Submit Compensation Form C. A. 2 without further delay.~~

_____

_____

Attachment

WBH:cnm

Tolson
Ladd
Nichols
Belmont
Clegg
Glavin
Harbo
Rosen
Tracy
Laughlin
Mohr
Tele. Rm.
Holloman
Gandy

OCT 9 1952
COMM-FBI

Standard Form 92
PROMULGATED DEC. 1947 BY
BUREAU OF THE BUDGET
CIRCULAR A-5 REV.

SUPERVISOR'S REPORT OF ACCIDENT

DO NOT USE FOR MOTOR VEHICLE OR AIRCRAFT ACCIDENT

(See Instructions on Back. Use Additional Sheets if Necessary)

Section I — REPORTING UNIT

1a. TO: *(Appropriate Headquarters)*
FBI, U.S.DEPT. OF JUSTICE, WASHINGTON 25,D.C.

b. FROM: *(Reporting Dept. etc., and location—Include town and State or foreign country)*
FEDERAL BUREAU OF INVESTIGATION, U. S. DEPT. OF JUSTICE, SAN ANTONIO FIELD DIVISION

2. ACCIDENT OCCURRED IN

GOVERNMENT OPERATION	CONTRACTOR OPERATION
X	

DO NOT USE — CODE

Section II — WHEN, WHERE, HOW, AND WHY ACCIDENT OCCURRED AND CORRECTIVE ACTION

3. DATE OF ACCIDENT: Aug. 13,1952 | 4. TIME: About 7:50 P.M. | 5. EXACT LOCATION OF ACCIDENT: 478 Federal Bldg. San Antonio, Texas

6. DESCRIPTION BY INJURED PERSON; IF PROPERTY DAMAGE ONLY, BY PERSONS MOST CLOSELY ASSOCIATED WITH ACCIDENT *(Tell the complete story of what happened; no signature required.)*
I attempted to open a bottle of Pepsi-Cola by applying pressure to the handle of a scissors which had been placed on the cap. Bottle broke below neck cutting 2 ½ inch gash on index finger of left hand.

7. DESCRIPTION BY RESPONSIBLE SUPERVISOR—CIVILIAN OR MILITARY *(What led up to the accident, how did accident actually happen? Explain if anything was wrong with equipment, material, or layout and what was done wrong. Be specific.)*
As far as I have been able to determine, accident happened as outlined under No. 6 above.

8. WHAT ACTUALLY HAS BEEN DONE TO CORRECT CONDITIONS CAUSING THE ACCIDENT?
Nothing has been done to correct this situation since it was pure carelessness on the part of Mr. Anderson.

9. WHAT REMAINS TO BE DONE TO CORRECT SUCH CONDITIONS AND WHY?

Section III — CONSEQUENCES AND RELATED DATA

10a. INJURY TO: *(Check one)*

REPORTING AGENCY		
(1) MILITARY PERSONNEL	(2) CIVILIAN PERSONNEL: X	(3) CONTRACTOR PERSONNEL
OTHER		
(4) OTHER FEDERAL AGENCY PERSONNEL	(5) NONFEDERAL PERSON	

10b. PROBABLE DISABILITY *(Check one)*

(1) DEATH	(4) TEMPORARY TOTAL
(2) PERMANENT TOTAL	(5) TEMPORARY PARTIAL
(3) PERMANENT PARTIAL	(6) FIRST AID: X

10c. ESTIMATED DAMAGE TO PROPERTY OR EQUIPMENT *(Fill in one or more)*

(1) REPORTING AGENCY	$ None
(2) CONTRACTOR*	$
(3) OTHER FEDERAL AGENCY	$
(4) NONFEDERAL	$

* *Contractor of reporting agency*

11. DESCRIPTION OF PROPERTY OR EQUIPMENT DAMAGED
None

12. OWNERSHIP OF PROPERTY OR EQUIPMENT DAMAGED *(Name and home address)*
Not Applicable

13. NAME AND HOME ADDRESS OF INJURED: Merton R. Anderson
803 Clower St., San Antonio 12,Texas

14. SEX: M
15. AGE: 32
16. BADGE OR SERVICE NO.:

17. REGULAR OCCUPATION OF INJURED
Clerk

18. OFFICIAL ASSIGNMENT AT TIME OF ACCIDENT
Security Clerk,San Antonio Field Division

19. NATURE OF INJURY AND PART OF BODY INVOLVED
Laceration of index finger of left hand.

20. DATE INJURED STOPPED WORK: Aug. 13, 1952

21. DATE INJURED RETURNED TO WORK: Aug. 14, 1952

Sec. IV — WITNESSES

22. NAMES AND ADDRESSES OF WITNESSES
C. Maxton Farrell,

William R. Swope

[redacted]

b6
b7C

Sec. V — SUPERVISOR

23. DATE: 9-26-52
TITLE *(Civilian or military)*: SPECIAL AGENT IN CHARGE,
SIGNATURE OF SUPERVISOR: [signature]

Section VI — REVIEW AND COMMENT

24. COMMENTS ON ADEQUACY OF CORRECTIVE ACTION TAKEN, OR PLANNED, INCLUDING PROGRESS ON PENDING ACTIONS

25. DATE | TITLE *(Civilian or military)* | SIGNATURE OF REVIEWING OFFICIAL

16—51071-1

INSTRUCTIONS

SCOPE: Form applies to every accident, except motor vehicle and aircraft, arising out of the operation of a Federal Department or Establishment which results in injury to a person, or damage to property.

This form may be used similarly for operations performed by contractors under the jurisdiction of the reporting department, item 1b. It is not a substitute for any report to the Bureau of Employees' Compensation, but the reverse side of Form C. A. 1 of that Bureau should hereafter not be used.

PREPARATION: Answers must be given to all items on the form except as noted below: Accidents resulting in injury only, require answers to all items except 10c, 11, and 12; accidents resulting in property damage only, require answers to all items except 10a, 10b, and 13 through 21 inclusive; accidents resulting in injury and property damage require answers to all items. If a single accident involves injury to more than one person or damage to the property of more than one owner, a separate Form 92 is to be filled out for each injured person or each owner of damaged property.

SECTION I

Item 2. GOVERNMENT OPERATION.—Work performed by Government forces.

CONTRACTOR OPERATION.—Operation performed by a contractor's forces under jurisdiction of the reporting department named in item 1b.

SECTION II

Item 3. Date of accident.

Item 4. Hour of day or military time.

Item 5. Building or other exact location. Include town and State or foreign country.

Items 6, 7. Items must provide all possible information on what happened and a basis for answering items 8 and 9.

SECTION III

Item 10a. Injury to—Self-explanatory.

REPORTING AGENCY.—Department or establishment indicated in item 1b.

Item 10b (1) DEATH.—Self-explanatory.

(2) PERMANENT TOTAL. — An injury which permanently and totally incapacitates a person from following any gainful occupation.

(3) PERMANENT PARTIAL.—An injury which results in the loss of any member or part of a member of the body, or any permanent impairment of functions of the body or part thereof to any degree less than permanent total disability.

(4) TEMPORARY TOTAL.—An injury other than the above which renders the injured person unable to perform a regularly established job on any day or shift subsequent to the day of injury (*including Saturdays, Sundays, and days off*).

Standard Form 92
PROMULGATED DEC. 1947 BY BUREAU OF THE BUDGET
CIRCULAR A-3 REV.

SUPERVISOR'S REPORT OF ACCIDENT

DO NOT USE FOR MOTOR VEHICLE OR AIRCRAFT ACCIDENT

(See Instructions on Back. Use Additional Sheets if Necessary)

Section I REPORTING UNIT

1a. TO: (*Appropriate Headquarters*): Chief of Engineers, Washington 25, D. C.

2. ACCIDENT OCCURRED IN: GOVERNMENT OPERATION: X; CONTRACTOR OPERATION:

DO NOT USE: CODE

b. FROM: (*Reporting Dept. etc., and location—Include town and State or foreign country*): Dept. of Army, Corps of Engineers, Ohio River Div. Huntington District, Huntington, W. Va.

Section II WHEN, WHERE, HOW, AND WHY ACCIDENT OCCURRED AND CORRECTIVE ACTION

3. DATE OF ACCIDENT: Oct. 8, 1947

4. TIME: 2 P.M.

5. EXACT LOCATION OF ACCIDENT: Station 9-00 of stream gaging sec., Highway bridge over Big Sandy River at Louisa, Ky.

6. DESCRIPTION BY INJURED PERSON, IF PROPERTY DAMAGE ONLY, BY PERSONS MOST CLOSELY ASSOCIATED WITH ACCIDENT (*Tell the complete story of what happened; no signature required*)

While making discharge measurement, I was lowering sounding weight to bottom of river by use of reel and crank. Submerged log hit cable, knocking crank out of hand. Crank handle struck nose and forehead.

7. DESCRIPTION BY RESPONSIBLE SUPERVISOR—CIVILIAN OR MILITARY (*What led up to the accident, how did accident actually happen? Explain if anything was wrong with equipment, material, or layout and what was done wrong. Be specific.*)

Discharge measurements were being made during highwater. Due to fact that the brake on the reel was defective, the sounding weight was being lowered by use of crank. Normally the sounding weight is lowered by using brake only. Crank should be replaced with hand-wheel.

8. WHAT ACTUALLY HAS BEEN DONE TO CORRECT CONDITIONS CAUSING THE ACCIDENT?

Defective brake has been repaired and hand-wheel ordered.

9. WHAT REMAINS TO BE DONE TO CORRECT SUCH CONDITIONS AND WHY?

Get approval for purchase of hand-wheel to replace crank. Such purchase requires approval by head of plant section.

Section III CONSEQUENCES AND RELATED DATA

10a. INJURY TO (*Check one*): REPORTING AGENCY: (1) MILITARY PERSONNEL; (2) CIVILIAN PERSONNEL; (3) CONTRACTOR PERSONNEL X. OTHER: (4) OTHER FEDERAL AGENCY PERSONNEL; (5) NONFEDERAL PERSON

10b. PROBABLE DISABILITY (*Check one*): (1) DEATH; (2) TEMPORARY TOTAL X; (3) PERMANENT TOTAL; (4) TEMPORARY PARTIAL; (5) PERMANENT PARTIAL; (6) FIRST AID

10c. ESTIMATED DAMAGE TO PROPERTY OR EQUIPMENT (*Fill in one or more*): (1) REPORTING AGENCY $ 100.00; (2) CONTRACTOR* $; (3) OTHER FEDERAL AGENCY $; (4) NONFEDERAL $

* *Contractor of reporting agency*

11. DESCRIPTION OF PROPERTY OR EQUIPMENT DAMAGED: Loss of sounding weight and discharge measurement device.

12. OWNERSHIP OF PROPERTY OR EQUIPMENT DAMAGED (*Name and home address*): Corps of Engineers, Huntington District, Huntington, W. Va.

13. NAME AND HOME ADDRESS OF INJURED: John D. Doe, 2000 Main St., Huntington, W.Va.

14. SEX: M

15. AGE: 43

16. BADGE OR SERVICE NO.: None

17. REGULAR OCCUPATION OF INJURED: Engineer Aide

18. OFFICIAL ASSIGNMENT AT TIME OF ACCIDENT: Stream gauging

19. NATURE OF INJURY AND PART OF BODY INVOLVED: Laceration and contusions on nose and forehead

20. DATE INJURED STOPPED WORK: Oct. 9, 1947

21. DATE INJURED RETURNED TO WORK: Oct. 11, 1947

Sec. IV WITNESSES

22. NAMES AND ADDRESSES OF WITNESSES: Ralph N. Black, 9097 South St., Huntington, W. Va.; James E. Brown, 8089 Tenth St., Huntington, W. Va.

Sec. V SUPERVISOR

23. DATE: Oct. 11, 47

TITLE (*Civilian or military*): Chief, Stream Gauging Section

SIGNATURE OF SUPERVISOR: Howard T. James

Section VI REVIEW AND COMMENT

24. COMMENTS ON ADEQUACY OF CORRECTIVE ACTION TAKEN, OR PLANNED, INCLUDING PROGRESS ON PENDING ACTIONS: Instructions have been issued that brake is to be used in lowering sounding weights with crank disengaged in all cases. Purchase of hand-wheels to replace all cranks has been approved.

25. DATE: 10-12-47

TITLE (*Civilian or military*): Chief, Engineering Div.

SIGNATURE OF REVIEWING OFFICIAL: John R. Randall

16—54071-1

SECTION III (Continued)

(5) TEMPORARY PARTIAL. — An injury which prevents the injured person from performing his own job on any day or shift subsequent to the day of injury, but does not prevent his performing another regularly established job.

(6) FIRST AID (*Medical Treatment Case*).—An injury which requires medical treatment only and does not result in loss of time.

Item 10c. Property or equipment includes material. Give closest estimate possible of damage; do not state "unknown," "undetermined." Each loss must be explained in item 11.

(1) REPORTING AGENCY.—Department or establishment indicated in item 1b.

Item 11. Include damage to material.

Item 18. Work or duty assignment by supervisor at time of accident.

Item 20. The date of the first day (*subsequent to the date shown in item 3*) when the injured commenced losing time.

Item 21. The day injured returned to work; report shall not be delayed beyond the end of calendar month for completion of this item.

SECTION IV

Item 22. Should be "eye witnesses" if available; if not, first persons hearing of accident from injured person or other sources.

SECTION V

Item 23. Supervisor responsible for the information in items 3–22, inclusive.

SECTION VI

Item 24. The designation of the reviewing official is the responsibility of the department or establishment but should be an operating official above the level of the supervisor indicated in item 23.

REMARKS:

USE ADDITIONAL PLAIN SHEETS OF PAPER IF NECESSARY

16—54071-1 U. S. GOVERNMENT PRINTING OFFICE

DO NOT MUTILATE THESE FORMS IN ANY WAY

Orig. Forw'd. to Bu of Empl Comp.
10/15/52

3

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

Federal Employees' Compensation Act of September 7, 1916, as amended

This notice should be submitted to the immediate superior by an injured civil employee of the Federal Government, or by someone on his behalf, within 48 hours after the injury. Notice may be given either personally or by mail. It should be retained by the official superior unless the injury causes disability for work beyond the day or shift when injury occurred, or results in any charge against the Bureau for medical expense, when it should be forwarded to the Federal Security Agency, Bureau of Employees' Compensation, together with the official superior's report of injury, Form C. A. 2. Before compensation is paid, written claim on Form C. A. 4 must be submitted to the Bureau.

Date of this notice _____, 19____

1. I hereby certify that I am employed as a Clerk
(Occupation)

at the San Antonio Field Division, INS, U. S. Department of Justice
(Place of employment)

and on Wednesday (Day of week), August 13th, (Date), 1952, at 7:50 P. (Hour, a. m. or p. m.) m.

I was injured in the performance of my duties at 478 Federal Bldg. San Antonio, Texas
(Location where injury occurred)

2. Cause of injury During my lunch period I was attempting to open a bottle of Pepsi-Cola with a scissors. The handle of the scissors had been placed over the cap and pressure was beingapplied on the blade when the bottle broke at the neck, cutting the forefinger of my left hand.
(Describe as best you can how and why injury occurred)

3. Nature of injury A cut two and one-quarter inches long by three-eighths inches deep on the forefinger of my left hand, necessitating nine stitches to close
(Name part of body affected—fractured left leg, bruised right thumb, etc.)

4. Names of witnesses to injury C. Paxton Farrell, William R. Scopa.

5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when Acting Supervisor SA Fred B.Caldwell telephonically advised about 8:00 P.". August 13, 1952.

This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me.

Name Herton R. Anderson

Address 803 Clover St. San Antonio, Texas
(Street and number)

(City or town) (State)

C. A. 1
Revised August 1, 1945

16—45863-2

SUPERVISOR'S REPORT OF INJURY

This Supervisor's Report of Injury is for use in the prevention of injuries
Departmental regulations will govern its use

Department Justice (Post Office, Interior. Veterans Adm., etc.) Bureau or office Federal Bureau of Investigation (U. S. Engineers, Bureau of Standards, etc.)

Place of employment San Antonio (Arsenal, navy yard, etc.) (City) (State) Division, shop, etc. Chief Clerk's Office

Name of injured employee Merton R. Anderson (Give first name fully) Age 32 Sex Male

Occupation Clerk Length of time at trade or occupation 1 years 5 months

1. Describe accident or health hazard fully (what injured was doing, what happened, etc.)

The accident which happened was as described by Mr. Anderson on the other side of this memo.

2. What unsafe conditions caused accident or industrial (occupational) disease? (For example: Defective brakes, no guard rail on scaffold, highly waxed floor, unguarded punch press, concentration of benzol fumes, etc.)

Mr. Anderson's method of trying to open the bottle was entirely unsafe as he did not have proper tools.

3. What was done wrong (unsafely) that caused accident or industrial (occupational) disease? (For example: Failure to wear provided goggles, using box or chair instead of ladder, using mushroomed chisel, jumping off moving car, etc.)

Mr. Anderson was wrong in trying to open a bottle with other than a regular bottle opener and particularly with a sharp instrument such as scissors.

4. What has been done to prevent similar occurrences?

Employees have been cautioned relative to carelessness.

5. What is recommended to prevent similar occurrences?

No change should be made other than employees should use good common sense in their every day work.

Signed by [signature] Title Special Agent in Charge Date 9/3/52

Reviewed by _____ Title _____ Date _____

Comments of Reviewing Official (with particular reference to answers to questions 4 and 5):

Extent of disability: (*check one*) First aid _____ Disabling injury X Death _____

Nature of injury cut 2½" long Part of body affected finger

DO NOT USE

U. S. GOVERNMENT PRINTING OFFICE 16—45868-1

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

Federal Employees' Compensation Act of September 7, 1916, as amended

This notice should be submitted to the immediate superior by an injured civil employee of the Federal Government, or by someone on his behalf, within 48 hours after the injury. Notice may be given either personally or by mail. It should be retained by the official superior unless the injury causes disability for work beyond the day or shift when injury occurred, or results in any charge against the Bureau for medical expense, when it should be forwarded to the Federal Security Agency, Bureau of Employees' Compensation, together with the official superior's report of injury, Form C. A. 2. Before compensation is paid, written claim on Form C. A. 4 must be submitted to the Bureau.

Date of this notice _____, 19____

1. I hereby certify that I am employed as a Clerk
(Occupation)
at the San Antonio Field Division, FBI, U. S. Department of Justice
(Place of employment)
and on Wednesday (Day of week), August 13th, (Date), 1952, at 7:50 P. (Hour, a. m. or p. m.) m.
I was injured in the performance of my duties at 478 Federal Bldg. San Antonio, Texas
(Location where injury occurred)

2. Cause of injury During my lunch period I was attempting to open a bottle of Pepsi-Cola with
(Describe as best you can how and why injury occurred)
a scissors. The handle of the scissors had been placed over the cap and pressure was beingapplied on the blade when the bottle broke at the neck, cutting the forefinger of my left hand.

3. Nature of injury A cut two and one-quarter inches long by three-eighths inches deep on the
(Name part of body affected—fractured left leg, bruised right thumb, etc.)
forefinger of my left hand, necessitating nine stitches to close

4. Names of witnesses to injury C. Harton Farrell, William R. Snope.

5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when Acting Supervisor SA Fred B.Caldwell telephonically advised about 8:00 P.M. August 13, 1952.

This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me.

Name Horton R. Anderson

Address 803 Clower St. San Antonio, Texas
(Street and number)

(City or town) (State)

C. A. 1
Revised August 1, 1945

16—45868-2

SUPERVISOR'S REPORT OF INJURY

This Supervisor's Report of Injury is for use in the prevention of injuries
Departmental regulations will govern its use

Department Justice (Post Office, Interior, Veterans Adm., etc.) Bureau or office Federal Bureau of Investigation (U. S. Engineers, Bureau of Standards, etc.)

Place of employment San Antonio (Arsenal, navy yard, etc.) (City) (State) Division, shop, etc. Chief Clerk's Office

Name of injured employee Merton K. Anderson (Give first name fully) Age 32 Sex Male

Occupation Clerk Length of time at trade or occupation 1 years 5 months

1. Describe accident or health hazard fully (what injured was doing, what happened, etc.)

The accident which happened was as described by Mr. Anderson on the other side of this memo.

2. What unsafe conditions caused accident or industrial (occupational) disease? (For example: Defective brakes, no guard rail on scaffold, highly waxed floor, unguarded punch press, concentration of benzol fumes, etc.)

Mr. Anderson's method of trying to open the bottle was entirely unsafe as he did not have proper tools.

3. What was done wrong (unsafely) that caused accident or industrial (occupational) disease? (For example: Failure to wear provided goggles, using box or chair instead of ladder, using mushroomed chisel, jumping off moving car, etc.)

Mr. Anderson was wrong in trying to open a bottle with other than a regular bottle opener and particularly with a sharp instrument such as scissors.

4. What has been done to prevent similar occurrences?

Employees have been cautioned relative to carelessness.

5. What is recommended to prevent similar occurrences?

No change should be made other than employees should use good common sense in their every day work.

Signed by A. H. McIntire Title Special Agent in Charge Date 9/3/52

Reviewed by _____ Title _____ Date _____

Comments of Reviewing Official (with particular reference to answers to questions 4 and 5):

Extent of disability: (*check one*) First aid _____ Disabling injury X Death _____

Nature of injury cut 2nd join Part of body affected finger

DO NOT USE

U. S. GOVERNMENT PRINTING OFFICE 16—45868-1

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

Federal Employees' Compensation Act of September 7, 1916, as amended

This notice should be submitted to the immediate superior by an injured civil employee of the Federal Government, or by someone on his behalf, within 48 hours after the injury. Notice may be given either personally or by mail. It should be retained by the official superior unless the injury causes disability for work beyond the day or shift when injury occurred, or results in any charge against the Bureau for medical expense, when it should be forwarded to the Federal Security Agency, Bureau of Employees' Compensation, together with the official superior's report of injury, Form C. A. 2. Before compensation is paid, written claim on Form C. A. 4 must be submitted to the Bureau.

Date of this notice _____, 19____

1. I hereby certify that I am employed as a Clerk (Occupation)

at the San Antonio Field Division, FBI, U. S. Department of Justice (Place of employment)

and on Wednesday (Day of week), August 13th, (Date), 1952, at 7:50 P. (Hour, a. m. or p. m.) m.

I was injured in the performance of my duties at 478 Federal Bldg. San Antonio, Texas (Location where injury occurred)

2. Cause of injury During my lunch period I was attempting to open a bottle of Pepsi-Cola with (Describe as best you can how and why injury occurred)
a scissors. The handle of the scissors had been placed over the cap and pressure was beingapplied on the blade when the bottle broke at the neck, cutting the forefinger of my left hand.

3. Nature of injury A cut two and one-quarter inches long by three-eighths inches deep on the (Name part of body affected—fractured left leg, bruised right thumb, etc.)
forefinger of my left hand, necessitating nine stitches to close

4. Names of witnesses to injury C. Maxton Farrell, William R. Swope.

5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when Acting Supervisor SA Fred B.Caldwell telephonically advised about 8:00 P.M. August 13, 1952.

This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me.

Name _____
Merton R. Anderson

Address 803 Clower St. San Antonio, Texas
(Street and number)

_____
(City or town) (State)

C. A. 1
Revised August 1, 1945

16—45868-2

SUPERVISOR'S REPORT OF INJURY

This Supervisor's Report of Injury is for use in the prevention of injuries
Departmental regulations will govern its use

Department Justice (Post Office, Interior, Veterans Adm., etc.) Bureau or office Federal Bureau of Investigation (U. S. Engineers, Bureau of Standards, etc.)

Place of employment San Antonio (Arsenal, navy yard, etc.) (City) (State) Division, shop, etc. Chief Clerk's Office

Name of injured employee Morton A. Anderson (Give first name fully) Age 32 Sex Male

Occupation Clerk Length of time at trade or occupation 1 years 5 months

1. Describe accident or health hazard fully (what injured was doing, what happened, etc.)

The accident which happened was as described by Mr. Anderson on the other side of this one.

2. What unsafe conditions caused accident or industrial (occupational) disease? (For example: Defective brakes, no guard rail on scaffold, highly waxed floor, unguarded punch press, concentration of benzol fumes, etc.)

Mr. Anderson's method of trying to open the bottle was entirely unsafe as he did not have proper tools.

3. What was done wrong (unsafely) that caused accident or industrial (occupational) disease? (For example: Failure to wear provided goggles, using box or chair instead of ladder, using mushroomed chisel, jumping off moving car, etc.)

Mr. Anderson was wrong in trying to open a bottle with other than a regular bottle opener and particularly with a sharp instrument such as scissors.

4. What has been done to prevent similar occurrences?

Employes have been cautioned relative to carelessness.

5. What is recommended to prevent similar occurrences?

No change should be made other than employes should use good common sense in their every day work.

Signed by E. A. McLaughlin Title Special Agent in Charge Date 2/3/52

Reviewed by _____ Title _____ Date _____

Comments of Reviewing Official (with particular reference to answers to questions 4 and 5):

Extent of disability: (*check one*) First aid _____ Disabling injury X Death _____

Nature of injury cut 2nd join Part of body affected finger

DO NOT USE

U. S. GOVERNMENT PRINTING OFFICE 16—45868-1

OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to UNITED STATES EMPLOYEES' COMPENSATION COMMISSION, 285 Madison Avenue, New York, N. Y., as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Commission for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department Justice (War, Navy, etc.) 2. Bureau or office San Antonio Division, FBI (Engineer, Navigation, etc.)
3. Place of employment 478 Federal Bldg. (Arsenal, navy yard, etc.), San Antonio (City), Texas (State)
4. Reporting office 478 Federal Bldg., San Antonio, Texas. (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred F. H. MC INTIRE

The injured employee

6. Name of injured employee MERTON R. ANDERSON (Give first name in full) 7. Age 32 8. Sex Male 9. Race White
10. Home address 803 Clower (Street and number), San Antonio (City or town), Texas (State)
11. Occupation and division Security Clerk, CCO (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? Yes If not, what work?
13. Total length of service with the Government as a civilian? 1 yr. six months
14. How long at present work in this establishment? 1 yr. five months
15. Dates of other injuries None
16. Rate of pay on date of injury, $ 3410 per ; and subsistence valued at $ None per ; and quarters valued at $ None per
17. Employee begins work at 4:30 p. m. (Hour, a. m. or p. m.) 18. Regular day's work ends 12:30 A. m. (Hour, a. m. or p. m.)
19. Hours worked per day 8 20. Days paid per week 5

The injury

21. Place where injury occurred 478 Federal Bldg., San Antonio, Texas. (Give exact location, as name or number of building and division, etc.)
22. Date of injury Aug. 13, 1952; day of week Wed.; hour of day 7:50 p. m. (a. m. or p. m.)
23. Date employee stopped work Aug. 13, 1952; day of week Wed.; hour of day 7:50 p. m. (a. m. or p. m.)
24. Date employee's pay stopped —, 19...; day of week —; hour of day — m. (a. m. or p. m.)
25. Has employee returned to work? Yes, August 14, 1952, 4:30 p.m. (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
    (a) Annual leave (Give exact dates)
    (b) Sick leave 8:00 p.m. 8/13/52 to 12:30 a.m., August 14, 1952 (Give exact dates)
    (c) Any other reason (Give exact dates)
27. Describe in full how injury occurred Employee was attempting to remove the cap from a bottle of Pepsi-Cola with the handle of a scissors. The handle had been placed on the cap and pressure was being applied to the scissor blade when the bottle broke below the neck.
28. State part of body injured and nature and extent of injury Laceration on index finger of left hand 2½ inches long and 3/8 inches deep, which severed numberous capillaries but did not sever the leader.
29. Did injury cause loss of any member or part of member? No If so, describe exactly However, employee's finger at present has not straightened out, although completely healed from outward appearances. Employee states finger is extremely sensitive around scar or injured part.
30. Was employee injured while in performance of duty? Yes If not, or in doubt, give detailed statement Mr. ANDERSON was on official duty at the office but was having his lunch during his rest period.
31. Was injury caused by:
    (a) Willful misconduct of the employee? No (b) Intention of employee to bring about injury or death of himself or another? No (c) Employee's intoxication? No
    (If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)
32. Was written notice of injury given within 48 hours? No If not, did immediate superior have actual knowledge of injury? Yes (Answer to question 5, Form C. A. 1. must be complete if notice was not given within 48 hours)
33. Names and addresses of witnesses to injury WILLIAM R. SWOPE, 151 El Monte, San Antonio, Texas, C. MAXTON FARRELL, [redacted] b6 b7C
    (If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)
34. Was injury caused by a third party other than a Government employee or agency? No If so, has employee been instructed in procedure under Commission's regulations? (A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case Dr. Hoelscher
36. How soon after injury? About 20 minutes
37. To what hospital sent? Emergency room, Baptist Memorial Hospital Location San Antonio, Texas
38. Name and address of physician now attending case None

Signed this 10th day of October, 1952
at San Antonio, Texas.

(Signature of reporting officer)
Special Agent in Charge
(Title)

C. A. 2
Revised March 1, 1942

(OVER)

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

I was in the steno pool immediately adjacent to the Chief Clerk's Office when I heard a popping noise which I thought was the cap being removed from the bottle. I turned and saw the injured running toward the sink and noticed a trail of blood in his wake. While FARRELL, the other Security Clerk secured the First Aid Kit from the supply room, I attempted to wash a few small bits of glass from the injured's forefinger and then inched the wound shut with a two inch bandage compress and bandaged same. The injured began to feel faint I administrered an ammonia ampoule with water. In the meantime FARRELL was attempting to locate a physician as I was of the opinion that the wound required stitches.

Signed this 10 day of October, 19 52 William R. Swope
(Signature of witness)

I was sitting at the desk at which the accident occurred at the time of the injury. The injured was attempting to open a bottle of Pepsi Cola by applying pressure to the cap of the bottle with the broad eye of the scissors' handle. When the bottle broke, I didn't know that ANDERSON'S finger had been cut but thought only that he had gone to the wash basin to wash the Pepsi Cola off his hands. I didn't know that the injury had occurred until I walked around the desk and observed a trail of blood on the floor leading to the wash basin. After noting that the injury was quite severe I ran to the adjoining supply room and got the first aid kit for R.C.O. SWOPE who had just entered the room. SWOPE washed and bandaged the wound while I tried to contact a doctor to place stitches in the laceration.

Signed this 10 day of October, 19 52 C Marion Farrell
(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that _____ (Name of employee) was given first-aid treatment, or examined, on _____, 19____, at _____ m., and _____ (Was or was not) disabled for work. Probable length of disability will be _____ In my opinion disability _____ (Was or was not) due to injury on _____, 19____

Nature of injury as found on examination _____

Hospitalized _____ Will return for further treatment _____

Discharged _____ Other disposition _____

Remarks _____

Signed this _____ day of _____, 19____

at _____

_____
(Signature of medical officer)

_____
(Title)

STANDARD FORM NO. 64

3-208

Office Memorandum • UNITED STATES GOVERNMENT

TO : SAC, San Antonio(Your file)

DATE: September 11, 1952

FROM : Director, FBI

~~PERSONAL AND CONFIDENTIAL~~

SUBJECT: MERTON R. ANDERSON
Clerk

( ) Rebulet _____.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) The Bureau is in receipt of Compensation Forms C. A. 1; however, it is requested that form C. A. 2 also be executed and forwarded to the Bureau as soon as possible.

67-NOT RECORDED

SEARCHED ..... INDEXED.....
SERIALIZED ..... FILED.....
SEP 11 1952
FBI - SAN ANTONIO

Bureau

46 OCT 16 1952

STANDARD FORM NO. 64

3-208

Office Memorandum • UNITED STATES GOVERNMENT

TO : SAC, San Antonio(Your file)

DATE: October 3, 1952

FROM : Director, FBI

SUBJECT: MERTON R. ANDERSON
Clerk

(X) Re attached form.
( ) Rebulet _____.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) Submit Compensation Form C. A. 2 without further delay.

Attachment

OCT 16 1952

WHEN WRITING THIS BUREAU ALWAYS REFER TO FILE NUMBER SHOWN BELOW

U. S. DEPARTMENT OF LABOR
Bureau of Employees' Compensation
Washington 25, D. C.

November 13, 1952

Address Only;
Bureau of Employees' Compensation
Washington 25, D. C.

IN REPLY REFER TO FILE NO. X-774254

The Director
U. S. Department of Justice
Federal Bureau of Investigation
Washington 25, D. C.

Dear Sir:

Reference is made to the case of Merton R. Anderson who was allegedly injured on August 13, 1952 while employed as a security clerk by your establishment.

It is noted in the records that this employee was examined on August 13, 1952 by Dr. Hoelscher. For the further consideration of this case, it is requested that you kindly have the claimant secure and submit a detailed medical report from Dr. Hoelscher on the enclosed Form CA-20.

Very truly yours,

JS:rkh

BUREAU OF EMPLOYEES' COMPENSATION

ENCLOSURE Form CA-20

RECORDED-45

ENCL. Encl. detached & sent to Emp. for Completion 12-2-52 wlt

67— 11/ — 40
Search J
Number
13 NOV 18 1952

17 DEC 17 1952

CA-228

: SAC San Antonio (Your file) December 17, 1952

: Director, FBI

Merton R. Anderson
Clerk

~~CONFIDENTIAL~~

( ) Rebulet 12-2-52.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) Submit Bureau of Employees' Compensation form CA-20.

_____

_____

Tolson
Ladd
Nichols
Belmont
Clegg
Glavin
Harbo
Rosen
Tra
Lau
Mohr
Tele. Rm.
Holloman
Gandy

WBH/mc

DEC 18

: SAC, San Antonio (Your file) December 2, 1952

: Director, FBI

Merton R. Anderson

~~PERSONAL AND CONFIDENTIAL~~

( ) Rebulet _____.

( ) Reurlet _____.

( ) Submit reply promptly.

( ) Schedule necessary physical examination and surep promptly.

( ) Advise Bureau re physical condition.

( ) Advise Bureau of present weight without clothing.

(X) Please have the attached form completed by the above's physician and return to the Bureau as soon as possible.

WBH/mc

Tolson
Ladd
Nichols
Belmont
Clegg
Glavin
Harbo
Rosen
Tracy
Laughlin
Mohr
Tele. Rm.
Holloman
Gandy

December 31, 1952

Bureau of Employees' Compensation
United States Department of Labor
Federal Security Building
Fourth and Independence Avenue, Southwest
Washington 25, D. C.

Your reference number X-774254

Gentlemen:

There is enclosed Employees' Compensation form C. A. 20, executed in connection with an injury sustained by Merton R. Anderson of this Bureau.

Very truly yours,

John Edgar Hoover
Director

Enclosure

Tolson
Ladd
Nichols
Belmont
Clegg
Glavin
Harbo
Rosen
Tracy
Laughlin
Mohr
Tele. Rm.
Holloman
Gandy

JMB/mc

Standard Form 88
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, ELDON ROGER		

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
803 Clover, San Antonio, Texas	Annual	23 Feb 55

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE: MILITARY	CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION AND
Male	Cau	3 6/12	4	F.B.I.	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN
21 Jul 20(34)	Wisconsin Dells, Misc.	

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: AVN HLD & PROC SV, 3700 USAF HOSP, LACKLAND AFB, SAN ANTONIO, TEX

16. OTHER INFORMATION

17. RATING OR SPECIALTY | TYPE MEDICAL CERTIFICATE (YES) | LAST SIX MONTHS

CLINICAL EVALUATION

NOTES.—*Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)*

NORMAL	ABNORMAL	(*Check each item in appropriate column; enter "N. E." if not evaluated*)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
X		21. MOUTH AND THROAT
X		22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)
X		23. DRUMS (*Perforation*)
X		24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60, and 61*)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (*Equality and reaction*)
X		27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)
X		28. LUNGS AND CHEST (*Include breasts*)
X		29. HEART (*Thrust, size, rhythm, sounds*)
X		30. VASCULAR SYSTEM (*Varicosities, etc.*)
X		31. ABDOMEN AND VISCERA (*Include hernia*)
X		32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate if indicated*)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (*Strength, range of motion*)
X		36. FEET
X		37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)
X		38. SPINE, OTHER MUSCULOSKELETAL
X		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (*Equilibrium tests under item 72*)
X		42. PSYCHIATRIC (*Specify any personality deviation*)
Females only		(*Check how done*)
—		43. PELVIC ☐ VAGINAL ☐ RECTAL

ENGL.

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively*)

O.—*Restorable teeth* /.—*Nonrestorable teeth* X.—*Missing teeth* XXX.—*Replaced by dentures* (6 X 8).—*Fixed bridge, brackets to include abutments*

RIGHT	X	X	3	X	5	6	7	8	9	10	11	12	X	14	15	LEFT
	32	X	31	29	28	27	26	25	24	23	22	21	20	19	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Dental work indicated

6X L E F 24 14 Class 2 48

X Scratched .....

Number 2 60

RECORDED-4

MAR 31 1955

FEDERAL BUREAU OF INVESTIGATION

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. 1.010			46. CHEST X-RAY (*Place, date, film number, result*)	47. SEROLOGY (*Specify test used and result*)
ALBUMIN	SUGAR	MICROSCOPIC		
neg	neg	—	LAFB, 23 Feb 55, neg.	Cardiolipin Microflocculation, neg

48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
—	O pos	—

55 MAR 31 1955

02288 THREE

Page 3-8

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: SLENDER	MEDIUM	HEAVY	OBESE	56. TEMP.
68	142	blond	hazel	☒	☐	☐	☐	98.6

57. BLOOD PRESSURE (*Arm at heart level*) — 58. PULSE (*Arm at heart level*)

SITTING	SYS. 124 / DIAS. 76	RECUMBENT	SYS. 110 / DIAS. 70	STANDING (5 min.)	MAR 30 MAR 30 10 '55 AM '55 / DIAS. 74	AFTER EXERCISE	78 MAR 55 7 110 08	2 MIN. AFTER	AM '55 80	RECUMBENT	64	AFTER STANDING 3 MIN.	80

59. DISTANT VISION		60. REFRACTION		61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/ —	RECD PERSONNEL SECTION	CX —	20/20	CORR. TO — BY —
LEFT 20/ 20	CORR. TO 20/ —	BY —	S. —	RECD PERSONNEL SECTION 20/20	CORR. TO — BY —

62. HETEROPHORIA (*Specify direction*) — ES — ET — EP — V. A. — PRISM DIV. — PRISM CONV. — FDC — FDD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and result*)	UNCORRECTED / CORRECTED
RIGHT 8.5 LEFT 8.0	Passes WT3-CV		

66. FIELD OF VISION	67. NIGHT VISION (*Test used and result*)	68. RED LENS	69. INTRAOCULAR TENSION
normal			normal

70. HEARING

RIGHT WV 15 /15 SV — /15
LEFT WV 15 /15 SV — /15

71. AUDIOMETER

	256	512	1024	2048	4096	8192
RIGHT						
LEFT						

72. PSYCHOLOGICAL AND PSYCHIATRIC TESTS (*Test used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

Denies all significant medical history.

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS: FURTHER SPECIALISTS' EXAMINATIONS INDICATED (*Specify*)

76. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)
☒ IS
— IS NOT QUALIFIED FOR Strenuous Physical Exertion

PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE
A. L. HEISER, 1st Lt USAF (MC), ARE

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*) — SIGNATURE

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

U. S. GOVERNMENT PRINTING OFFICE 16—62285-1

tc - 24

ATTACHMENT TO STANDARD FORM 88
(Revised July 21, 1952)

Report of Medical Examination

FOR INFORMATION AND GUIDANCE OF MEDICAL EXAMINER:

The following portions of the attached examination report form need not be completed:

2	67	
3	68	
11	69	
14	71	(unless other examination indicates desirable)
17		
62		
65	72	

Item 48, the electrocardiogram, is not required unless the examinee is over 35 years of age or unless other examination indicates such is desirable.

If the examinee is an applicant, the Chest X ray and blood type and Rh factor (Items 46 and 49) are not necessary unless the facilities for affording same are readily available to the examiner.

FOR ALL EXAMINEES, WHETHER CLERICAL OR SPECIAL AGENT APPLICANTS OR EMPLOYEES:

The medical examiner should answer the following question:

Examinee is (is or is not) qualified for strenuous physical exertion. (Designate which)

FOR ALL MALE EMPLOYEES OR APPLICANTS:

The medical examiner is requested to answer the following:

Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

No

If answer is "yes" please specify.

IT IS ESSENTIAL THAT ALL STATEMENTS IN ITEMS 59, 61, 64 AND 70 PERTAINING TO VISUAL ACUITY, COLOR VISION AND HEARING BE COMPLETED IN DETAIL.

[signature]
(Signature of Medical Examiner)

24 Feb 55
(Date)

ENCLOSURE 62-94145-[illegible]

Standard Form 88
(Rev. Aug. 1950)
Prescribed by
Bureau of the Budget
Circular A-24

REPORT OF MEDICAL EXAMINATION

1. LAST NAME, FIRST NAME, MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, M[illegible] E.	FBI	

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
21 CORTE ANA, MILLBRAE, CALIF.	ANNUAL	21 MAR 1956

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE		10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	CAUC.	21	5		

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	IS HILLS, IS	

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
USNH, [illegible] KLA., C[illegible]IF	

17. RATING OR SPECIALTY — TIME IN THIS CAPACITY: TOTAL — LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	ABNORMAL	(*Check each item in appropriate column; enter "N E" if not evaluated*)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
X		21. MOUTH AND THROAT
X		22. EARS - GENERAL (*Ext & ext canals. Tympanic membr under items 24 and 25*)
X		23. DRUMS (*Perforation*)
	X	24. EYES - GENERAL (*Vision, ocular and refractive, under items 26, 27, and 61*)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (*Equality and reaction*)
X		27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)
X		28. LUNGS AND CHEST (*Include breasts*)
X		29. HEART (*Thrust, size, rhythm, sounds*)
X		30. VASCULAR SYSTEM (*Varicosities, etc.*)
X		31. ABDOMEN AND VISCERA (*Include hernia*)
X		32. ANUS AND RECTUM (*Hemorrhoids, fistulae. Prostate, if indicated*)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (*Strength, range of motion*)
X		36. FEET
X		37. LOWER EXTREMITIES (*Except feet. Strength, range of motion*)
X		38. SPINE, OTHER MUSCULOSKELETAL
X		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (*Equilibrium tests under item 22*)
X		42. PSYCHIATRIC (*Specify any personality deviation*)
Females only		(*Check how done*)
		43. PELVIC ☐ VAGINAL ☐ RECTAL

NOTES. *Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)*

#24 : 1mm hemangioma rt lower lid. Eye consult. NCD

61

205 [illegible]

(*Continue in item 73*)

5-16-56 — Mrs B. Jones

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively*)

O.—*Restorable teeth* X.—*Missing teeth* (6 × 8).—*Fixed bridge, brackets to include abutments*
/.—*Nonrestorable teeth* XXX.—*Replaced by dentures*

RIGHT																LEFT
X	2X	3	4X	5	O	7	8	9	10	11	12	X	14	15	X	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

NCD

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. [illegible]D			46. CHEST X-RAY (*Place, date, film number, result*)	47. SEROLOGY (*Specify test used and result*)
ALBUMIN	SUGAR	MICROSCOPIC		
N G	N G	[illegible]	23344-C N G 3-21	KAHN N G

48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
SBL # 73		

16—62288-1

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMP.
[illegible]	15[illegible]	BLOND [illegible]	[illegible] HAZEL	SLENDER ☐ MEDIUM ☒ HEAVY ☐ OBESE ☐	[illegible] AL

57. BLOOD PRESSURE (*Arm at heart level*)

SITTING	SYS 1[illegible]4 DIAS 78	RECUM-BENT	SYS 1[illegible]4 DIAS 76	STANDING (3 min.)	SYS DIAS	MAY 9 11 14 AM '51	

58. PULSE (*Arm at heart level*)

SITTING	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN
74	84	78		

59 DISTANT VISION			60. REFRACTION			61. NEAR VISION		
RIGHT 20	20	CORR. TO 20/	BY	S	CX		CORR. TO	BY
LEFT 20	20	CORR TO 20	BY	S	CX		CORR. TO	BY

62. HETEROPHORIA (*Specify distance*) ES[illegible] EX R. H L. H PRISM DIV. PRISM CONV PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT LEFT	AOC 40-18/18		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS	69. INTRAOCULAR TENSION

70. HEARING	71. AUDIOMETER							72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	8000 8192	
RIGHT WV /15 SV /15	RIGHT								
LEFT WV 15 /15 SV 15 /15	LEFT								

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

#48: OC[illegible]ASIONAL ATRIAL ECTOPIC BEATS. SINUS ARHYTHRUIA. NCD

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

NONE

75. RECOMMENDATIONS— FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

NONE

76. PHYSICAL PROFILE

P	L	L	H	E	S

77. EXAMINEE (*Check*)

☒ IS ☐ IS NOT QUALIFIED FOR SE[illegible]ICOUS PHYSICAL EXE[illegible]TION

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

PHYSICAL CATEGORY

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

H. B[illegible] L, LC [illegible] F. DeW. Williams

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*) — SIGNATURE

for C.L. BOHE C[illegible]PT, DC USN J. E. Froehlke

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE 195[illegible] O 243413 16 62258 1

ANDERSON, M.R.

ATTACHMENT TO STANDARD FORM 88
(Revised July 21, 1952)

Report of Medical Examination

FOR INFORMATION AND GUIDANCE OF MEDICAL EXAMINER:

The following portions of the attached examination report form need not be completed:

2	67	
3	68	
11	69	
14	71	(unless other examination indicates desirable)
17		
62		
65	72	

Item 48, the electrocardiogram, is not required unless the examinee is over 35 years of age or unless other examination indicates such is desirable.

If the examinee is an applicant, the Chest X ray and blood type and Rh factor (Items 46 and 49) are not necessary unless the facilities for affording same are readily available to the examiner.

FOR ALL EXAMINEES, WHETHER CLERICAL OR SPECIAL AGENT APPLICANTS OR EMPLOYEES:

The medical examiner should answer the following question:

Examinee IS (is or is not) qualified for strenuous physical exertion. (Designate which)

FOR ALL MALE EMPLOYEES OR APPLICANTS:

The medical examiner is requested to answer the following:

Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

NONE

If answer is "yes" please specify.

IT IS ESSENTIAL THAT ALL STATEMENTS IN ITEMS 59, 61, 64, and 70 PERTAINING TO VISUAL ACUITY, COLOR VISION AND HEARING BE COMPLETED IN DETAIL.

M.D. J.C. WILLIAMS LT MC USNR
(Signature of Medical Examiner)

INITIAL M.R.A.

67-241457-67

ENCLOSURE

21 Mar 56
(Date)

Standard Form 88
(Rev. Aug. 1950)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-24

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	Civilian	
4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
21 Corte Anna, Millbrae, Calif.	Annual Physical	20 MAR 57

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY	9. TOTAL YRS. GOVT. SERVICE CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	W			Dept. of Justice	FBI

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
21 July 20	Wisconsin	Mrs. Merton R. Anderson, wife (same as #4)

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
US Army Dispensary, PSFC	

17. RATING OR SPECIALTY — TIME IN THIS CAPACITY: TOTAL — LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	ABNORMAL	(*Check each item in appropriate column: enter "N. E." if not evaluated*)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
X		21. MOUTH AND THROAT
X		22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)
X		23. DRUMS (*Perforation*)
X		24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60, and 61*)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (*Equality and reaction*)
X		27. OCULAR MOTILITY (*Associated parallel movements. nystagmus*)
X		28. LUNGS AND CHEST (*Include breasts*)
X		29. HEART (*Thrust, size, rhythm, sounds*)
X		30. VASCULAR SYSTEM (*Varicosities, etc.*)
X		31. ABDOMEN AND VISCERA (*Include hernia*)
X		32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate if indicated*)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (*Strength, range of motion*)
X		36. FEET
X		37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)
X		38. SPINE, OTHER MUSCULOSKELETAL
X		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (*Equilibrium tests under item 72*)
X		42. PSYCHIATRIC (*Specify any personality deviation*)
Females only		(*Check how done*)
		43. PELVIC ☐ VAGINAL ☐ RECTAL

NOTES.—Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)

32. Prostate Normal.

146
DISCLOSURE

(Continue in item 73)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively*)

O.—*Restorable teeth* /.—*Nonrestorable teeth* X.—*Missing teeth* XXX.—*Replaced by dentures* (6×8).—*Fixed bridge, brackets to include abutments*

RIGHT																	LEFT
	X	X	3	X	5	X	X	8	9	10	11	12	X	14	15	X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

2 Apt Ser 51-63
Class 3
Under treatment 41

LABORATORY FINDINGS

45. URINALYSIS: SP. GR. 1.016			46. CHEST X-RAY (*Place, date, film number, result*)	47. SEROLOGY (*Specify test used and result*)
ALBUMIN	SUGAR	MICROSCOPIC		
Neg	Neg	Ne g	Lungs are Ne g	C. L. MIC Floc Neg

48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
normal	O	

4 APR 11 1957

16—62288-1

ci 39" cc 35" abd 3 0"

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: SLENDER / MEDIUM / HEAVY / OBESE	56. TEMP.
68½"	154	Blond	Hazel	☐ / ☒ / ☐ / ☐	98.6

RECD HADMIN. DIV. FBI APR 10 8 04 AM '5776

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
	SYS.	RECUMBENT	SYS.	STANDING (*3 min.*)	SYS.	SITTING	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN.
SITTING	DIAS. 118 / 68		DIAS.		DIAS.			64		

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION		
RIGHT 20/ 20	CORR. TO 20/	BY	S.	CX	J-1	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S.	CX	J-1	CORR. TO	BY

62. HETEROPHORIA: (*Specify distance*) ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD

Normal at 2 0 feet

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT Normal LEFT Normal	Ishihara-Normal		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS	69. INTRAOCULAR TENSION
			No Increase

70. HEARING	71. AUDIOMETER							72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
		250 *256*	500 *512*	1000 *1024*	2000 *2048*	3000 *2896*	4000 *4096*	8000 *8192*
RIGHT WV 15 /15 SV 15 /15	RIGHT	0	10	0	10		20	20
LEFT WV 15 /15 SV 15 /15	LEFT	15	15	5	10		10	15

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

No significant or interval history since last phy examination 1956.

(*Use additional sheets of plain paper if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

None

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. PHYSICAL PROFILE					
P	U	L	H	E	S
1	1	1	1	1	1

77. EXAMINEE (*Check*)
☒ IS
☐ IS NOT QUALIFIED FOR STRENUOUS PHYSICAL EXERTION.

Strenuous Physical Exertion and use of Firearms.

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

PHYSICAL CATEGORY			
A	B	C	E
X			

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
M. J. SEID, M. D.	Martin J. Seid
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1953—O-243413 16 - 62288-1

ANDERSON, MERTON R.

ATTACHMENT TO STANDARD FORM 88
(Revised July 25, 1956)

Report of Medical Examination

FOR INFORMATION AND GUIDANCE OF MEDICAL EXAMINER:

The following portions of the attached examination report form need not be completed:

2	67	
3	68	
11	69	
14	71	(Item 71, audiometer examinations, should be afforded whenever possible.)
17		
62		
65	72	

Item 48, the electrocardiogram, is not required unless the examinee is over 35 years of age or unless other examination indicates such is desirable.

If the examinee is an applicant, the Chest X-ray and blood type and Rh factor (Items 46 and 49) are not necessary unless the facilities for affording same are readily available to the examiner.

FOR ALL EXAMINEES, WHETHER CLERICAL OR SPECIAL AGENT APPLICANTS OR EMPLOYEES:

The medical examiner should answer the following question:

Examinee ___is___ qualified for strenuous physical exertion. (Designate which)
(is or is not)

FOR ALL MALE EMPLOYEES OR APPLICANTS:

The medical examiner is requested to answer the following:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms? ☐ Yes ☒ No

2. Does examinee have any defects prohibiting safe operation of motor vehicles?
☐ Yes ☒ No

If answer is "yes" please specify.

IT IS ESSENTIAL THAT ALL STATEMENTS IN ITEMS 59, 61, 64 AND 70 PERTAINING TO VISUAL ACUITY, COLOR VISION AND HEARING BE COMPLETED IN DETAIL.

M. R. Reed
(Signature of Medical Examiner)

March 20 53
(Date)

MRA
Initials

C-7111-51-63

OPTIONAL FORM NO. 10

UNITED STATES GOVERNMENT

Memorandum

TO : DIRECTOR, FBI
ATTN: PERSONNEL SECTION

DATE: 3/16/64

FROM : SAC, LOS ANGELES

SUBJECT: MERTON R. ANDERSON
SPECIAL AGENT
CONTACT WITH POSSIBLE
TUBERCULAR PATIENT, 3/3/64

This will advise that on 3/3/64, SA MERTON R. ANDERSON of the Los Angeles Office, while performing his assigned investigative duties, interviewed ARTHUR MICHAEL GASTON, subject of LA file 26-39638, concerning a stolen vehicle. This interview was conducted at the Prison Ward, Los Angeles County Sheriff's Office (LACSO), Floor 13, Los Angeles County Hospital, Los Angeles, Calif. The interview lasted for approximately 55 minutes, during which time GASTON wore a surgical-type mask except while smoking several cigarettes.

A review of the records of the Prison Ward of the Los Angeles County Hospital on 3/3/64 by Deputy RICHARD SCOBEL, Badge 383, LACSO, revealed that GASTON had been admitted as a possible tubercular patient on 3/2/64, for test purposes.

SA ANDERSON will have the regular chest x-ray in connection with his annual physical examination on 4/1/64. Another chest x-ray will be obtained within the following six months and the results forwarded to the Bureau.

The above is furnished to the Bureau so it may be made a matter of record in the personnel file of SA ANDERSON.

3 - Bureau
2 - Los Angeles
(1 - 26-39638)
(1 - Personnel File,
SA M.R. ANDERSON)
MRA:jss
(5)

REC-133

93

MAR 10 1964

8 MAR 24 1964

7619

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-32 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-106

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	**

4. HOME ADDRESS (Number, street or R.F.D., city or town, zone and State)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
923 W. Lucille W. Covina, California	ANNUAL PHYSICAL	4./1/64

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	13	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisconsin	Wife - Lois Anderson Same as #4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

REC-141

67- 24747 94

2 APR 20 1964

NEUROLOGIC

(Continue in item 73)

44. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively.)

O—Restorable teeth
/—Nonrestorable teeth
X—Missing teeth
XXX—Replaced by dentures
(6 X 8)—Fixed bridge, brackets to include abutments

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X	X	X		X	X						X			X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

#13 MISSING SPACE CLOSED.

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.017
B. ALBUMIN Neg.
C. SUGAR Neg.
D. MICROSCOPIC 0-1 WBC 1-2 RBC. Few mucous threads

46. CHEST X-RAY (Place, date, film number and result) USPHS SAN PEDRO 4-1-64 #76 19 - Normal

47. SEROLOGY (Specify test used and result) Non-reactive

48. EKG NSA

49. BLOOD TYPE AND RH FACTOR Not required

50. OTHER TESTS WBC 8600. Hemoglobin 15.1 gm.

71

MRA

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
5-8	162½	Brown	Hazel				✓		98

57. BLOOD PRESSURE (*Arm at heart level*) — 58. PULSE (*Arm at heart level*)

A. SITTING	SYS. 110 / DIAS. 76	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						68	80	68		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 15 CORR. TO 20/	BY S. OX	R-J1 CORR. TO BY
LEFT 20/ 15 CORR. TO 20/	BY S. OX	L-J1 CORR. TO BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT N LEFT N	P.I. Plates - OK		CORRECTED
66. FIELD OF VISION N	67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV 15 /15 SV 20 /15

LEFT WV 15 /15 SV 20 /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☑ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN: JOSEPH A. KITTERMAN, MD (R) — SIGNATURE: Joseph A. Kitterman M.D

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR ~~PHYSICIAN~~ (*Indicate which*): GRESHAM T. FARRAR, DMD, DENTAL SURGEON — SIGNATURE: Gresham T. Farrar DMD

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1961—O-612730 #21-B

Standard Form 89
(Rev. Aug. 1950)
Bureau of the Budget,
Circular A-82

REPORT OF MEDICAL HISTORY

89-103

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
923 W. Lucille W. Covina, California	ANNUAL PHYSICAL	4/1/64

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	13	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisconsin	Wife - Lois Anderson Same as #4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	****

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*

Good.

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	69	Good		
MOTHER	68	Good		
SPOUSE	37	Good		
BROTHERS AND SISTERS	44	Good		
CHILDREN				
Son	18	Good		

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE:

YES	NO	(*Check each item*)	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
	X	HAD DIABETES	
X		HAD CANCER	Grandfather
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM *(Arthritis)*	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY *(Fits)*	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)	YES	NO	(*Check each item*)
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS *(Night sweats)*		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS *(Inc. infantile)*
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
X	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT	X		LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS	X		ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
	X	HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (*Check each item*)						22. FEMALES ONLY: A. HAVE YOU EVER—			B. COMPLETE THE FOLLOWING:	
X		WORN GLASSES		X	ATTEMPTED SUICIDE			BEEN PREGNANT		AGE AT ONSET OF MENSTRUATION
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER			HAD A VAGINAL DISCHARGE		INTERVAL BETWEEN PERIODS
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS			BEEN TREATED FOR A FEMALE DISORDER		DURATION OF PERIODS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD			HAD PAINFUL MENSTRUATION		DATE OF LAST PERIOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION			HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY	

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU (*Check one*)
One	MONTHS 156 months	Special Agent, FBI	☒ RIGHT HANDED ☐ LEFT HANDED

MRA

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
		27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF:	
	X	A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.	
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS	
		D. OTHER MEDICAL REASONS (*If yes, give reasons*)	
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?	
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)	
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)	
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)	
X		32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*)	Tonsilectomy, in Jan. ~~196~~ 1943
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)	
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)	
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)	Dr. Harold Owens, M.D. 2010 Wilshire Blvd., Los Angeles, Calif. for ear fungus
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)	
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)	
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)	
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)	

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Merton R. Anderson	Merton R. Anderson

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

Occasional vertigo treated with Marin which controls it well.

****

Does not wear glasses now

***

***

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
JOSEPH A. KITTERMAN, MD (R)	4-8-64	Joseph A. Kitterman MD	

U.S. GOVERNMENT PRINTING OFFICE : 1959—O-527655

FD-300 (Rev. 10-10-62)

-1-3-

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	14	68
3	17	69
4	62	72
9	65	76
11	67	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in each ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☑ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

   ☑ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

   ☑ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☑ No
   If recommendation is based on a factor other than above standard, indicate basis _____

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☑ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☑ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

Joseph A. Kittleman MD
(Signature of Medical Examiner)

4-1-64
(Date)

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-32 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-106

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1340 W. 6th St., Los Angeles, Calif.	ANNUAL PHYSICAL	4/5/65

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	14	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisconsin	Wife - Lois Anderson, same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U.S. PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
✓	18. HEAD, FACE, NECK, AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	X
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 69, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
✓	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

Chronic otitis externa (L)

REC-135 4/7/65

ENCLOSURE # 1965

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth*
/—*Nonrestorable teeth*
X—*Missing teeth*
XXX—*Replaced by dentures*
(6 X 8)—*Fixed bridge, brackets to include abutments*

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X		X		X	X						X				
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Pt. has partial upper & lower denture

N.A.P.

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.006	46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN	neg.	USPHS, San Pedro, Calif., #7619, 4-5-65: Healthy chest.
C. SUGAR	neg.	
D. MICROSCOPIC	1-3 WBC, 1-2 RBC	

47. SEROLOGY (*Specify test used and result*)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL: Non-reactive	No significant abnormality	Not required	HEMATOLOGY: WBC-8,300, Hemoglobin-16.

MAP

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
5' 8"	@ 160 lbs.	Brown	Hazel				✓		98.6

57. BLOOD PRESSURE (*Arm at heart level*) 58. PULSE (*Arm at heart level*)

A. SITTING	SYS. 120 / DIAS. 78	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						64	96	68		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 15 CORR. TO 20/	BY S. OX	R J 1 CORR. TO BY
LEFT 20/ 15 CORR. TO 20/	BY S. OX	R J 1 CORR. TO BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT LEFT	P. S. Plates - O.K.		CORRECTED
66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV 15 /15 SV 20 /15

LEFT WV 15 /15 SV 20 /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

Otitis externa, Chronic ©

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☑ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN
FRANK J. PISCHKE, MD., SURGEON

SIGNATURE Frank J. Pischke

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR ~~PHYSICIAN~~ (*Indicate which*)
EARL C. HEWITT, DDS., Dental Director

SIGNATURE Earle C. Hewitt DDS

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1961—O-612730 #31-B

Standard Form 89
(Rev. Aug. 1950)
BUREAU OF THE BUDGET
CIRCULAR A-32

REPORT OF MEDICAL HISTORY

89-103

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***
4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
1340 W. 6th St., Los Angeles, Calif.	ANNUAL PHYSICAL	4/5/65

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	14	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisconsin	Wife - Lois Anderson, same as #4
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS		**16. OTHER INFORMATION**
U.S. PUBLIC HEALTH, San Pedro, Calif.		***

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*

Good

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	70	good		
MOTHER	69	good		
SPOUSE	38	good		
BROTHERS AND SISTERS	45	good		
CHILDREN	19	good		

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE:

YES	NO	(Check each item)	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
	X	HAD DIABETES	
	X	HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM *(Arthritis)*	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY *(Fits)*	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS *(Night sweats)*		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS *(Inc. infantile)*
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
		HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER *(Check each item)*					
X		WORN GLASSES		X	ATTEMPTED SUICIDE
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD
	X	WORN A BRACE OR BACK SUPPORT			BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY A. HAVE YOU EVER—		B. COMPLETE THE FOLLOWING:
	BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
	HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS
	BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS
	HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
	HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU *(Check one)*
one	MONTHS 14 years	FBI Special Agent	☒ RIGHT HANDED ☐ LEFT HANDED

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
X		32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*) — Tonsilectomy, Jan. 1943, U. S. Air Force Age - 21 yrs.
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*) — October, 1962, ear fungus, and running ears- Dr. H. Owens, 2010 Wilshire, Los Angeles, Calif.
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R. Anderson

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

Chronic ear infection since 1961-62, being treated

Glasses worn 20 years ago - not now

***

***

***

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
F. J. FISCHKE, MD., SURGE[illegible]	4-5-65	[signature]	

U.S. GOVERNMENT PRINTING OFFICE : 1959—O-527655

FD-300 (Rev. 10-10-62)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	14	68
3	17	69
4	62	72
9	65	76
11	67	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☑ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☑ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☑ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☑ No
If recommendation is based on a factor other than above standard, indicate basis _____

MPA

REC'D - ADMIN DIV.
APR 27 [illegible]

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☑ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☑ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

[signature]
(Signature of Medical Examiner)

4/13/65
(Date)

FD-277 (Rev. 3-6-63)
OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27
5010-106

UNITED STATES GOVERNMENT

Memorandum

TO : Director, FBI

DATE: 10/1/64

FROM : SAC, Los Angeles

Attention: Personnel Section

SUBJECT: MERTON R. ANDERSON, SA
SSN 393-05-3331
Exposure to Tuberculosis

☒ Remylet 3/16/64.
☐ ReBulet _____.

☐ Re physical examination _____.
☐ Dental work was completed on _____.
☐ Vision has been corrected to _____. Employee specifically instructed _____ (date) by _____ (name of person giving instruction) that he can operate a Bureau car only when wearing the necessary glasses.
☒ Results of ☒ chest X ray ☐ patch test ☐ urinalysis ☐ serology were negative.
☐ Enclosed physician's statement indicates he is qualified for strenuous physical exertion and use of firearms.
☐ Enclosed are ☐ paid ☐ unpaid medical bills.
☐ Attached are Bureau of Employees' Compensation forms _____.
☐ Physical examination reports are enclosed.
☐ Employee is scheduled for physical examination on _____.
☐ Physical examination report has been reviewed and initialed.
☐ Employee returned to active duty _____.
☐ Employee's physical condition is _____.
☐ UACB he is being removed from limited duty.
☐ UACB he is being placed on limited duty.

Remarks:

No further action
Ltr 6
10-5-64

67-N... RDED 63

lal

WCR THREE

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-32 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-106

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***

4. HOME ADDRESS (*Number, street or R.F.D., city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1340 West Sixth Street Los Angeles, California	ANNUAL PHYSICAL	4/7/66

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	15	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson Same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
✓	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
✓	42. PSYCHIATRIC (*Specify any personality deviation*)	
	~~43. PELVIC~~ (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

REC-135 67-2[illegible]-114
Searched
MAY 9 1966

CLOSURE

THRU

(Continue in item 73)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

○—*Restorable teeth* /—*Nonrestorable teeth* X—*Missing teeth* XXX—*Replaced by dentures* (6 X 8)—*Fixed bridge, brackets to include abutments*

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X		X		X	X						X			X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

P/P present

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.002	46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN: Negative	D. MICROSCOPIC: Occasional squamous epith & wbc/hpf.	USPHS, OPC, SAN PEDRO, CALIF.# 76 19 Chest X-Ray: Healthy Chest
C. SUGAR: Negative		

47. SEROLOGY (*Specify test used and result*)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL: Non-Reactive	Otherwise completely Normal	-	Hematology: Wbc. - 8,600 Hemoglobin - 15.6

6 MAY 66

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
157 lbs	5'8"	Brown	Hazel			✓			98.6

57. BLOOD PRESSURE (*Arm at heart level*) — 58. PULSE (*Arm at heart level*)

A. SITTING	SYS. 130 / DIAS. 76	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						84	96	84		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 20 CORR. TO 20/	BY S. OX	R-J1 CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. OX	L-J1 CORR. TO BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION RIGHT / LEFT	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED / CORRECTED
	P. I. Plate - OK		
66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING	71. AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15 SV 20 /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15 SV 20 /15	RIGHT									
	LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. [X] IS QUALIFIED FOR

B. [ ] IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN
KEN WINSTON, M.D. SURGEON

SIGNATURE Ken Winston, M.D.

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST ~~OR PHYSICIAN~~ (*Indicate which*)
EARL C. HEWITT, D.D.S. D.D.

SIGNATURE Earl C. Hewitt D.D.S.

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1961—O-612730 #31-B

Standard Form 89
(Rev. Aug. 1950)
BUREAU OF THE BUDGET
CIRCULAR A-32

REPORT OF MEDICAL HISTORY

89-103

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1340 West Sixth Street Los Angeles, California	ANNUAL PHYSICAL	4/7/66

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	15	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson Same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. *(Follow by description of past history, if complaint exists)*

Good

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER	71	good		
MOTHER	70	good		
SPOUSE	39	good		
BROTHERS AND SISTERS	1- 46	good		
CHILDREN	1- 20	good		

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE:

YES	NO	*(Check each item)*	RELATION(S)
	X	HAD TUBERCULOSIS	
	X	HAD SYPHILIS	
X		HAD DIABETES	mother
	X	HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM *(Arthritis)*	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY *(Fits)*	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	*(Check each item)*	YES	NO	*(Check each item)*	YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS *(Night sweats)*		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS *(Inc. infantile)*
	X	MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
	X	FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE		X	HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
X	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
	X	HAY FEVER		X	ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER *(Check each item)*						22. FEMALES ONLY. A. HAVE YOU EVER—			B. COMPLETE THE FOLLOWING:	
X		WORN GLASSES		X	ATTEMPTED SUICIDE			BEEN PREGNANT		AGE AT ONSET OF MENSTRUATION
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER			HAD A VAGINAL DISCHARGE		INTERVAL BETWEEN PERIODS
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS			BEEN TREATED FOR A FEMALE DISORDER		DURATION OF PERIODS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD			HAD PAINFUL MENSTRUATION		DATE OF LAST PERIOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION			HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY	

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU *(Check one)*
one	MONTHS dont apply	Special Agent, FBI	☒ RIGHT HANDED ☐ LEFT HANDED

CLOSURE 4-21-66 7-11-66 mcg

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF:
	X	A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
X		32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*) — Removal of tonsils. USAF, Hondo, Texas January, 1943.
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*) — Treated for running ears, by Dr. H. Owens, 2010 Wilshire, Los Angeles, Calif.
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R. Anderson

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

20.- removal fungal infection + left ear

21.- wore glasses 8 years ago (not now)

32 + 35 - self explanatory

***

***

***

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
KEN WINSTON, M.D SURGEON	April 7, 1964	Ken Winston	

U.S. GOVERNMENT PRINTING OFFICE : 1959—O-527655

FD-300 (Rev. 10-10-62)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	14	68
3	17	69
4	62	72
9	65	76
11	67	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

   ☒ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

   ☒ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
   If recommendation is based on a factor other than above standard, indicate basis _____

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5' 4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5' 6"	124 - 133	130 - 143	138 - 157
5' 7"	128 - 137	134 - 148	143 - 162
5' 8"	132 - 141	138 - 152	147 - 166
5' 9"	136 - 146	142 - 156	151 - 170
5' 10"	140 - 150	146 - 161	155 - 175
5' 11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6' 1"	152 - 163	158 - 176	169 - 190
6' 2"	156 - 167	163 - 181	174 - 195
6' 3"	160 - 171	168 - 186	178 - 200
6' 4"	169 - 180	178 - 196	188 - 210
6' 5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, examinee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____
(Signature of Medical Examiner)

August 7, 1966
(Date)

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-52 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-108

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	***

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1340 West Sixth Street Los Angeles, California	ANNUAL PHYSICAL	4/13/67

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	16	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson Same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	—
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (*Equilibrium, tests under item 72*)	
	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

Lt. Otitis Externa.

REC-137

24145T-123

APR 28 1967

22

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth* /—*Nonrestorable teeth* X—*Missing teeth* XXX—*Replaced by dentures* (6 X 8)—*Fixed bridge, brackets to include abutments*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT	X	X			X	X							X		X		LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X					O					X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

P/p w/in use

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.026

B. ALBUMIN Negative

C. SUGAR Negative

D. MICROSCOPIC Essentially Negative

46. CHEST X-RAY (*Place, date, film number and result*)
USPHS, OPC, SAN PEDRO, CALIF.# 76 19
CHEST X-RAY: Healthy Chest

47. SEROLOGY (*Specify test used and result*)
VDRL: Non-Reactive

48. EKG No change from last exam

49. BLOOD TYPE AND RH FACTOR

50. OTHER TESTS
HEMATOLOGY: Wbc. 6,750;
Hemoglobin - 13.4.

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
~~5'7"~~ 5'8"	163 #	Brown	Hazel				✓		98.6

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. 118 DIAS. 74	B. RECUMBENT	SYS. DIAS.	C. STANDING (5 min.)	SYS. DIAS.	A. SITTING 72	B. AFTER EXERCISE 100	C. 2 MIN. AFTER 72	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 15 CORR. TO 20/	BY S. CX	R-J1 CORR. TO BY
LEFT 20/ 15 CORR. TO 20/	BY S. CX	L-J1 CORR. TO BY

62. HETEROPHORIA (Specify distance)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT	P.I. Plates - O K		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING		71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV 15 /15 SV 20 /15			250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15 SV 20 /15		RIGHT									
		LEFT									

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE					
P	U	L	H	E	S

77. EXAMINEE (Check)

A. [X] IS QUALIFIED FOR

B. [ ] IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

A	B	C	E

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN: B.M. CHAUSER, M.D. SURGEON — SIGNATURE: B. Chauser

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

81. TYPED OR PRINTED NAME OF ~~DENTIST OR PHYSICIAN~~ (Indicate which): L.J. WISMAN, D.D.S. — SIGNATURE: L.J. Wisman D.D.S.

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

* U.S. GOVERNMENT PRINTING OFFICE : 1962 O—647407

FD-300 (Rev. 2-9-67)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	9	62	69
3	11	65	72
4	14	67	76
8	17	68	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

67-24142-53

MRA

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5'6"	124 - 133	130 - 143	138 - 157
5'7"	128 - 137	134 - 148	143 - 162
5'8"	132 - 141	138 - 152	147 - 166
5'9"	136 - 146	142 - 156	151 - 170
5'10"	140 - 150	146 - 161	155 - 175
5'11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6'1"	152 - 163	158 - 176	169 - 190
6'2"	156 - 167	163 - 181	174 - 195
6'3"	160 - 171	168 - 186	178 - 200
6'4"	169 - 180	178 - 196	188 - 210
6'5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

Barry M. Clausen
Signature of Medical Examiner

5/13/67
Date

Standard Form 88
(Rev. Jan. 1956)
Bureau of the Budget
Circular A-32 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-106

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	**

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1340 West Sixth Street Los Angeles, California	ANNUAL PHYSICAL	4/12/68

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	17	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson Same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
V	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

REC 132

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth*
/—*Nonrestorable teeth*
X—*Missing teeth*
XXX—*Replaced by dentures*
(6 X 8)—*Fixed bridge, brackets to include abutments*

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X		Void	X	X	X						X			X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.014
B. ALBUMIN Negative
C. SUGAR Negative
D. MICROSCOPIC 2-4 Wbc.
Rare Rbc.

46. CHEST X-RAY (*Place, date, film number and result*)
USPHS, OPC, SAN PEDRO, CA.# 76 19
CHEST X-RAY: Healthy Chest

47. SEROLOGY (*Specify test used and result*)
VDRL: Non-Reactive

48. EKG
See #73 -

49. BLOOD TYPE AND RH FACTOR
-

50. OTHER TESTS
Hematology: Wbc. 6,400
Hemoglobin - 15.05 gms.

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
5' 8"	162	Brown	Gray				X		98

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. 110 DIAS. 66	B. RECUMBENT	SYS. DIAS.	C. STANDING (3 min.)	SYS. DIAS.	A. SITTING 68	B. AFTER EXERCISE 88	C. 2 MIN. AFTER 64	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/ 16	CORR. TO 20/	BY	S.	OX	J2 CORR. TO	BY
LEFT 20/ 16	CORR. TO 20/	BY	S.	OX	J2 CORR. TO	BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	01 Plates OK		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING		71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15 SV 20 /15			250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15 SV 20 /15		RIGHT									
		LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

NO. 46 - Photocopy of EKG attached - no change from tracing of 4/67

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. [X] IS QUALIFIED FOR

B. [ ] IS NOT QUALIFIED FOR

***

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

***

79. TYPED OR PRINTED NAME OF PHYSICIAN: JOHN L. OHMAN, M.D. SR. ASST. SURG.

SIGNATURE: Johnson

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)

G.D. TAYLOR, D.D.S.

SIGNATURE: G. D. Taylor, D.D.S.

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1961—O-612730 #31-B

FD-300 (Rev. 2-9-67)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	9	62	69
3	11	65	72
4	14	67	76
8	17	68	

46. Is necessary unless facilities for affording same are not readily available.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5'6"	124 - 133	130 - 143	138 - 157
5'7"	128 - 137	134 - 148	143 - 162
5'8"	132 - 141	138 - 152	147 - 166
5'9"	136 - 146	142 - 156	151 - 170
5'10"	140 - 150	146 - 161	155 - 175
5'11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6'1"	152 - 163	158 - 176	169 - 190
6'2"	156 - 167	163 - 181	174 - 195
6'3"	160 - 171	168 - 186	178 - 200
6'4"	169 - 180	178 - 196	188 - 210
6'5"	174 - 185	182 - 202	192 - 216

REC'D ADMIN. DIV. F B I APR 30 1968 3 25 PM '68

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____

[illegible] [illegible] [illegible]

Signature of Medical Examiner

4-17-68

Date

7 Apr 1969 pb

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-22 (Rev.)

REPORT OF MEDICAL EXAMINATION

SSN: [redacted]

88-115
BOB APPROVAL No. 80-R157

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R	SPECIAL AGENT	-

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1234 S. Broadmoor, West Covina, Calif	ANNUAL	1 Apr 1969

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Caucasian	3½	18	FBI	-

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
(48) 21 Jul 1920	Wisconsin Dells, Wisc	Lois Anderson (wife) Same as 4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
807 MED GP (SAC) MARCH AFB CALIF	DAFSC: -

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS
-	-	-

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
X	18. HEAD, FACE, NECK AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS -GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
X	23. DRUMS (Perforation)	
X	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
X	25. OPHTHALMOSCOPIC	
X	26. PUPILS (Equality and reaction)	
X	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
X	28. LUNGS AND CHEST (Include breasts)	
X	29. HEART (Thrust, size, rhythm, sounds)	
X	30. VASCULAR SYSTEM (Varicosities, etc.)	
X	31. ABDOMEN AND VISCERA (Include hernia)	
X	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (Strength, range of motion)	
X	36. FEET	
X	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
X	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
X	40. SKIN, LYMPHATICS	
X	41. NEUROLOGIC (Equilibrium tests under item 72)	
X	42. PSYCHIATRIC (Specify any personality deviation)	
-	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

32. Rectal and prostate normal

128

JMB

(Continue in item 73)

44. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively.)

O—Restorable teeth
/—Nonrestorable teeth
X—Missing teeth
XXX—Replaced by dentures
(X)—Fixed bridge, brackets to include abutments

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	X	X	X			X	X						X			X	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Exam 3 Class 1 Qualified

LABORATORY FINDINGS

45. URINALYSIS- A. SPECIFIC GRAVITY	1.015	48. CHEST X RAY (Place, date, film number and result)
B. ALBUMIN	Neg	March AFB Calif 1 Apr 1969 14" x 17"
C. SUGAR	Neg	Film 69-5308 Neg
D. MICROSCOPIC	Neg	

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL Neg	WNL	A POS	HEMAT 46%

4½

JMB

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD (Check one) SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
68	164	Brown	Blue		X			98.6

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS 140 DIAS. 88	B RECUMBENT	SYS. - DIAS. -	C STANDING (3 min.)	SYS - DIAS. -	A SITTING	B. AFTER EXERCISE	C 2 MIN. AFTER	D. RECUMBENT	E AFTER STANDING 3 MIN.
						80	-	-	-	-

59. DISTANT VISION		60. REFRACTION				61. NEAR VISION		
RIGHT 20/	20 CORR. TO 20/ -	BY -	S. -	CX -		20/40 CORR. TO	20/20	BY lenses
LEFT 20/	20 CORR. TO 20/ -	BY -	S. -	CX -		20/100 CORR. TO	20/20	BY worn

62. HETEROPHORIA (*Specify distance*)

ES° - EX° - R. H. - L. H. - PRISM DIV. - PRISM CONV. xxxxxxxx Ortho CT PC - PD -

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	
RIGHT -	LEFT -	VTS-CV passes	-	UNCORRECTED - CORRECTED -

66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION
Normal	-	-	Normal 7.5 gms 18.5 OU

70. HEARING		71. ISO 1964 AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
RIGHT WV __/15 SV __/15	RIGHT	-	20	15	10	30	45	55	-	-
LEFT WV __/15 SV __/15	LEFT	-	10	10	10	20	10	15	-	

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

EXAMINEE DENIES ALL SIGNIFICANT INTERVAL HISTORY SINCE LAST PE

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

61. Defective visual acuity, correctable.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

-

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. [X] IS QUALIFIED FOR (IS) FBI ANNUAL

B [ ] IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

-

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN
JOHN E. GREENE, CAPT, USAF, MC

SIGNATURE John E. Greene

80. TYPED OR PRINTED NAME OF PHYSICIAN -

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*) -

SIGNATURE

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY -

SIGNATURE

NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE 1968—0-297-325

FD-300 (Rev. 10-14-68)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print): ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

2	9	62	69
3	11	65	72
4	14	67	76
8	17	68	

45, 46 and 47. Required for all Special Agent applicants but not for any other applicant unless the examining physician deems one, two or all three of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

49. Is necessary unless facilities for affording same are not readily available.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

67-24145-1

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5'6"	124 - 133	130 - 143	138 - 157
5'7"	128 - 137	134 - 148	143 - 162
5'8"	132 - 141	138 - 152	147 - 166
5'9"	136 - 146	142 - 156	151 - 170
5'10"	140 - 150	146 - 161	155 - 175
5'11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6'1"	152 - 163	158 - 176	169 - 190
6'2"	156 - 167	163 - 181	174 - 195
6'3"	160 - 171	168 - 186	178 - 200
6'4"	169 - 180	178 - 196	188 - 210
6'5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

CAPT. JOHN E. GREENE
FV 3203297
807 Medical Group
March AFB, Calif. 92508
Signature of Medical Examiner

18 Apr 69
Date

Standard Form 88
(Rev. June 1956)
Bureau of the Budget
Circular A-32 (Rev.)

REPORT OF MEDICAL EXAMINATION

88-108

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	

4. HOME ADDRESS (*Number, street or RFD, city or town, zone and State*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	4/7/70

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	19	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson Same as #4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (*Equilibrium, tests under item 72*)	/
	42. PSYCHIATRIC (*Specify any personality deviation*)	/
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	/

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

REC-133 67- 1 1 1 31
Search'd Numb'd
MAY 6 1970

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols above or below number of upper and lower teeth, respectively.*)

O—*Restorable teeth*
/—*Nonrestorable teeth*
X—*Missing teeth*
XXX—*Replaced by dentures*
(6 X 8)—*Fixed bridge, brackets to include abutments*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT	X		X	O	X	X	/						(6 X 8)			X	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X	X	X									O	X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES
P/Present
#2 Bifurcation involvment
#14 " "

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.022
B. ALBUMIN Neg.
C. SUGAR Neg
D. MICROSCOPIC 1-2 WBC. Sl.amt.of amorph.urate

46. CHEST X-RAY (*Place, date, film number and result*)
Essentially normal chest; no change.

47. SEROLOGY (*Specify test used and result*)
Non-reactive

48. EKG
WNL

49. BLOOD TYPE AND RH FACTOR

50. OTHER TESTS
WBC 7650 Hemoglobin 15.3

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
5' 8"	165	Brown	Hazel			✓			98

57. BLOOD PRESSURE (*Arm at heart level*) 58. PULSE (*Arm at heart level*)

A. SITTING	SYS. 114 / DIAS. 70	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						84	100	88		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 16 CORR. TO 20/	BY S. CX	J3 CORR. TO J1 BY glasses
LEFT 20/ 16 CORR. TO 20/	BY S. CX	J3 CORR. TO J1 BY glasses

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION RIGHT LEFT	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED / CORRECTED
	P-I plates OK.		
66. FIELD OF VISION	67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING	71. AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15 SV 20 /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15 SV 20 /15	RIGHT									
	LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

H-A-Hy →

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

A	B	C	E
	1		

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

NORMAN M. PANITCH, MD SAS (R)

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST ~~OR PHYSICIAN~~ (*Indicate which*) DONALD R. GRIFFITH, SADS (R)	SIGNATURE D. R. Griffith, DDS (Ret)
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

* U.S. GOVERNMENT PRINTING OFFICE : 1962 O—647407

FD-300 (Rev. 3-27-69)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	62	69
4	11	65	72
8	14	67	76
	17	68	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☑ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☑ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☑ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☑ No
If recommendation is based on a factor other than above standard, indicate basis _____

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5'6"	124 - 133	130 - 143	138 - 157
5'7"	128 - 137	134 - 148	143 - 162
5'8"	132 - 141	138 - 152	147 - 166
5'9"	136 - 146	142 - 156	151 - 170
5'10"	140 - 150	146 - 161	155 - 175
5'11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6'1"	152 - 163	158 - 176	169 - 190
6'2"	156 - 167	163 - 181	174 - 195
6'3"	160 - 171	168 - 186	178 - 200
6'4"	169 - 180	178 - 196	188 - 210
6'5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☑ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☑ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

N Sandler MD
Signature of Medical Examiner

4-7-70
Date

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm on Medical Records
FPMR 101-11 800-3

REPORT OF MEDICAL EXAMINATION

1 LAST NAME–FIRST NAME–MIDDLE NAME	2 GRADE AND COMPONENT OR POSITION	3 IDENTIFICATION NO
ANDERSON, MERTON R	SPECIAL AGENT	

4 HOME ADDRESS (Number, street or RFD, city or town State and ZIP Code)	5 PURPOSE OF EXAMINATION	6 DATE OF EXAMINATION
1234 S. BROADMOOR AVENUE W. COVINA, CALIFORNIA	ANNUAL PHYSICAL	5 APRIL 71

7 SEX	8 RACE	9 TOTAL YEARS GOVERNMENT SERVICE		10 AGENCY	11 ORGANIZATION UNIT
Male	Caucasian	MILITARY 3 Yrs½	CIVILIAN	FBI	* * *

12 DATE OF BIRTH	13 PLACE OF BIRTH	14 NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/ 20 (50)	WISCONSIN DELLS, WISC	LOIS ANDERSON (WIFE) Same as line # 4

15 EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16 OTHER INFORMATION
USAF REGIONAL HOSPITAL ,MARCH AFB, CALIF	***

17 RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column enter "NE" if not evaluated)	ABNORMAL
X	18 HEAD, FACE, NECK, AND SCALP	
X	19 NOSE	
X	20 SINUSES	
X	21 MOUTH AND THROAT	
X	22 EARS–GENERAL (Int & ext canals) (Auditory acuity under items 70 and 71)	
X	23 DRUMS (Perforation)	
X	24 EYES–GENERAL (Visual acuity and refraction under items 59 60 and 67)	
X	25 OPHTHALMOSCOPIC	
X	26 PUPILS (Equality and reaction)	
X	27 OCULAR MOTILITY (Associated parallel movements nystagmus)	
X	28 LUNGS AND CHEST (Include breasts)	
X	29 HEART (Thrust, size, rhythm, sounds)	
X	30 VASCULAR SYSTEM (Varicosities, etc.)	
X	31 ABDOMEN AND VISCERA (Include hernia)	
X	32 ANUS AND RECTUM (Hemorrhoids fistulae) (Prostate if indicated)	
X	33 ENDOCRINE SYSTEM	
X	34 G U SYSTEM	
X	35 UPPER EXTREMITIES (Strength, range of motion)	
X	36 FEET	
X	37 LOWER EXTREMITIES (Except feet) (Strength range of motion)	
X	38 SPINE, OTHER MUSCULOSKELETAL	
X	39 IDENTIFYING BODY MARKS, SCARS, TATTOOS	
X	40 SKIN, LYMPHATICS	
X	41 NEUROLOGIC (Equilibrium tests under item 72)	
X	42 PSYCHIATRIC (Specify any personality deviation)	
	43 PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES (Describe every abnormality in detail Enter pertinent item number before each comment Continue in item 73 and use additional sheets if necessary)

21. TE CHLD

(Continue in item 73)

REC-133

67-24451-135

Searched ____ Numbered 45

2 JUL 13 1971

ENCLOSURE

THREE

44 DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth)

Restorable teeth: 0 / 1 2 3 / 32 31 30
Non-restorable teeth: / / 1 2 3 / 32 31 30
Missing teeth: x / 1 2 3 / 32 31 30 x
Replaced by dentures: x x x / 32 31 30 / x x x
Fixed Partial dentures: (x) / 1 2 3 / 32 31 30 / (x)

RIGHT																LEFT
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
X	X	X										X	X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

EXAM TYPE 3 CLASS 1

QUAL

LABORATORY FINDINGS

45 URINALYSIS A SPECIFIC GRAVITY	1.009	46 CHEST X RAY (Place, date, film number and result) 14x 17
B ALBUMIN	Neg	
C SUGAR	Neg	MARCH AFB Ca, 4/5/71 Film # 1178 WNL
D MICROSCOPIC		

47 SEROLOGY (Specify test used and result)	48 EKG	49 BLOOD TYPE AND RH FACTOR	50 OTHER TESTS
VDRL - Neg	WNL		HCT 49 %

21 JUL 21 1971

88 117 02

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: (Check one)	SLENDER	MEDIUM	HEAVY	OBESE	56. TEMPERATURE
5-8"	165	Brown	Gray				X		98.6

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. 130 / DIAS. 82	B. RECUMBENT	SYS. – / DIAS. –	C. STANDING (3 min.)	SYS. – / DIAS. –	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3-MIN.
						76	86	74	–	–

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION		
RIGHT 20/ 20	CORR. TO 20/ 20	BY	S.	CX	20/100 CORR. TO	20/25	BY
LEFT 20/ 20	CORR. TO 20/ 20	BY	S.	CX	20/100 CORR. TO	20/30	BY

62. HETEROPHORIA *(Specify distance)*

ES° – EX° – R. H. – L. H. – PRISM DIV. – ~~PRISM CONV.~~ CT ORTHO PC – PD –

63. ACCOMMODATION		64. COLOR VISION *(Test used and result)*	65. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT –	LEFT –	VTS - CV (PASSES)		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION *(Test used and score)*	68. RED LENS TEST	69. INTRAOCULAR TENSION
Normal	M13.1	–	15.9

70. HEARING			71. ISC 1964 AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
				250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
RIGHT WV	/ 15 SV	/ 15	RIGHT	–	10	0	5	30	65	70	–	
LEFT WV	/ 15 SV	/ 15	LEFT	–	5	0	0	5	10	45	–	

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

NO INTERVAL HISTORY

EXAMINEE DENIES ALLO OTHER SIGNIFICANT MEDICAL AND SURGICAL HISTORY

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE *(Check)*

A. [X] IS QUALIFIED FOR (IS) GENERAL (FBI) S

B. [ ] IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
STEPHEN T URAY CAPT USAF MC	S Stephen T Uray
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

☆U.S. GOVERNMENT PRINTING OFFICE: 1970 — 406-748

FD-309 (Rev. 3-27-69)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	62	69
4	11	65	72
8	14	67	76
	17	68	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☑ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☑ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☑ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☑ No
If recommendation is based on a factor other than above standard, indicate basis _____

Enclosed

MRA

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5'6"	124 - 133	130 - 143	138 - 157
5'7"	128 - 137	134 - 148	143 - 162
5'8"	132 - 141	138 - 152	147 - 166
5'9"	136 - 146	142 - 156	151 - 170
5'10"	140 - 150	146 - 161	155 - 175
5'11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6'1"	152 - 163	158 - 176	169 - 190
6'2"	156 - 167	163 - 181	174 - 195
6'3"	160 - 171	168 - 186	178 - 200
6'4"	169 - 180	178 - 196	188 - 210
6'5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☑ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☑ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____

S W Turay
Signature of Medical Examiner

4/5/71
Date

FD-277 (Rev. 3-6-63)
OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27
5010-106

UNITED STATES GOVERNMENT

Memorandum

TO : Director, FBI

DATE: 7/7/71

FROM : SAC, Los Angeles

Attention: Personnel Section

SUBJECT: MERTON R. ANDERSON, SA
Physical Examination

☐ Remylet _____.
☐ ReBulet _____.

☒ Re physical examination 4/5/71.
☐ Dental work was completed on _____.
☐ Vision has been corrected to _____. Employee specifically instructed _____ (date) by _____ (name of person giving instruction) that he can operate a Bureau car only when wearing the necessary glasses.
☐ Results of ☐ chest X ray ☐ patch test ☐ urinalysis ☐ serology were negative.
☐ Enclosed physician's statement indicates he is qualified for strenuous physical exertion and use of firearms.
☐ Enclosed are ☐ paid ☐ unpaid medical bills.
☐ Attached are Bureau of Employees' Compensation forms _____.
☒ Physical examination reports are enclosed.
☐ Employee is scheduled for physical examination on _____.
☐ Physical examination report has been reviewed and initialed.
☐ Employee returned to active duty _____.
☐ Employee's physical condition is _____.
☐ UACB he is being removed from limited duty.
☐ UACB he is being placed on limited duty.

Remarks:

Report received Los Angeles office this date.

NOT RECORDED-2

PID

111

3-451 (Rev. 2-29-68)

December 27, 1971

Bureau of Employees' Compensation
United States Department of Labor

Box 36022
450 Golden Gate Avenue
San Francisco, California 94102

Your File No.
Date of Injury

~~Merton R. Anderson~~
(Name)

Gentlemen:

☐ Reference is made to your letter dated _____.

☒ Enclosed are compensation forms and/or other information (indicated below), relative to injuries or diseases incurred by the above-named employee of this Bureau.

☒ CA-1's ☒ CA-2's ☐ ☐ ☐

☐ The desired information is being obtained and will be furnished to your agency within the near future.

☐ The following information is enclosed:

MAILED 12
DEC 28 1971
FBI

Very truly yours,

J. Edgar Hoover

John Edgar Hoover
Director

Enc. (4)
1 - SAC, Los Angeles (Personal Attention). See note page #2.
RGS
(4)

5 DEC 1971

MAIL ROOM ☐ TELETYPE UNIT ☐

Letter to Bureau of Employees' Compensation
Note to SAC, Los Angeles (Personal Attention).
RE: Merton R. Anderson

Advise Bureau if SA intends to take civil action against third party. Insure SA does not sign a release without approval from Miss Sofia P. Petters, Assistant Counsel for Employees' Compensation, Office of the Solicitor, United States Department of Labor, Washington, D. C. 20210. In addition, the Bureau should be advised every 60 days; unless, of course, more frequent correspondence is necessary. Also, on compensation form CA-2 item #34 was changed to yes. Correct your copy.

FD-277 (Rev. 3-6-63)
OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27
5010-106

UNITED STATES GOVERNMENT

Memorandum

TO : Director, FBI

DATE: 12/20/71

FROM : SAC, Los Angeles

Attention: Personnel Section

SUBJECT: SA MERTON R. ANDERSON
COMPENSATION MATTER

☐ Remylet _____.
☐ ReBulet _____.

☐ Re physical examination _____.
☐ Dental work was completed on _____.
☐ Vision has been corrected to _____. Employee specifically instructed
_____ (date) by _____ (name of person giving instruction) that he can operate a Bureau car only when wearing the necessary glasses.
☐ Results of ☐ chest X ray ☐ patch test ☐ urinalysis ☐ serology were negative.
☐ Enclosed physician's statement indicates he is qualified for strenuous physical exertion and use of firearms.
☐ Enclosed are ☐ paid ☐ unpaid medical bills.
☒ Attached are Bureau of Employees' Compensation forms C.A. 1 and C.A. 2 _____.
☐ Physical examination reports are enclosed.
☐ Employee is scheduled for physical examination on _____.
☐ Physical examination report has been reviewed and initialed.
☐ Employee returned to active duty _____.
☐ Employee's physical condition is _____.
☐ UACB he is being removed from limited duty.
☐ UACB he is being placed on limited duty.

67-NOT RECORDED

Remarks:

Bulet to BEC
re CA-1's + CA-2's
note to SAC
12-27-71

1 - Bureau (Encs. 4) ENCLOSURE
2 - Los Angeles 2 det rep
(1 - 66-4907) 12-27-71
/cea
(3)

ENCLOSURE

U.S. DEPARTMENT OF LABOR
Bureau of Employees' Compensation

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE
(Under the Federal Employees' Compensation Act)

INSTRUCTIONS

This form should be completed by the injured employee or someone on his behalf whenever an injury is sustained in the performance of duty and given to his immediate superior within 48 hours. It should be placed in the employee's official personnel file unless the injury causes disability for work beyond the day when it occurred; is likely to result in prolonged treatment or permanent disability; or in a charge for medical or related expenses when it should be forwarded to this Bureau with Form CA-2, Official Superior's Report of Injury. This form is also completed whenever an employee believes he suffers from a disease related to his employment. (See Sections 1.2, 1.3, 2.2 and 2.3 of the Bureau's Regulations.)

The immediate superior should also complete the reverse side of this form.

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*
Anderson, Merton Roger

2. DATE OF THIS NOTICE *(Mo., day, yr.)*
Dec. 17, 1971

3. PLACE OF EMPLOYMENT *(Name and location of office or establishment)*
Federal Bureau of Investigation, Los Angeles, California

4. DATE OF INJURY *(Mo., day, yr.)*
Dec. 17, 1971

5. OCCUPATION
Special Agent

6. HOUR OF INJURY *(a.m. or p.m.)*
10:00 A.M.

7. PLACE OR LOCATION WHERE INJURY OCCURRED
[redacted]

b6
b7C

8. CAUSE OF INJURY *(Describe how and why injury occurred)*
I came to [redacted] to interview Mrs. Gloria ~~May McCann in connection with an official matter.~~ Mrs. McCann had restrained her dog by placing him on a leash. I bent down to pat the ~~dog on the head and he bit me, breaking the skin on the forefinger~~ and large fingers of the left hand.

9. NATURE OF INJURY *(Name part of body affected—fractured left leg, bruised right thumb, etc.)*
Lacerations on forefinger and large fingers of left hand.

10. NAMES OF WITNESSES TO INJURY
Mrs. Gloria May Mc Cann, [redacted]

11. IF THIS NOTICE WAS NOT GIVEN WITHIN 48 HOURS AFTER THE INJURY, EXPLAIN REASON FOR DELAY. IF EARLIER NOTICE WAS GIVEN, VERBAL OR WRITTEN, STATE WHEN AND TO WHOM.
Notice given to immediate supervisor, NICHOLAS MC GAHAN, JR., at approximately 11:00 A.M., 12/17/71.

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.

12. SIGNATURE
Merton R Anderson

13. HOME ADDRESS OF INJURED EMPLOYEE
1234 S. Broadmoor Ave. West Covina, California

The immediate superior should submit a statement and secure statements of witnesses where possible. The statements should tell just what each personally knows about the injury, and how and when such knowledge was obtained.

14. DATE CA-1 RECEIVED BY AGENCY *(Mo., day, yr.)*	15. CA-1 RECEIVED BY WHOM
12/17/71	Nicholas Mc Gahan, Jr.

16. STATEMENT OF IMMEDIATE SUPERIOR

~~At approximately 11:00 a.m, 12/17/71 MERTON R. ANDERSON advised~~ me that during the course of an official investigation he was ~~bitten by a dog on the left hand. ANDERSON was instructed by~~ me to obtain medical care and report to the office nurse upon ~~his arrival back in the office. The injury did not cause~~ ANDERSON to be away from his official duties for leave purposes.

17. SIGNATURE OF IMMEDIATE SUPERIOR	18. DATE *(Mo., day, yr.)*
Nicholas Mc Gahan Jr.	12/17/71

19. STATEMENT OF WITNESS

20. SIGNATURE OF WITNESS	21. DATE *(Mo., day, yr.)*

22. STATEMENT OF WITNESS

23. SIGNATURE OF WITNESS	24. DATE *(Mo., day, yr.)*

U.S GOVERNMENT PRINTING OFFICE : 1964 OF—723-862

OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department Justice (Army, Navy, etc.) 2. Bureau or office Federal Bureau of Investigat (Engineer, Navigation, etc.)
3. Place of employment FBI Office (Arsenal, navy yard, etc.), Los Angeles (City), California (State).
4. Reporting office FBI Office, Los Angeles, California (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred Wesley G. Grapp

The injured employee

6. Name of injured employee Merton R. Anderson (Give first name in full) 7. Age 51 8. Sex M 9. Citizenship U. S.
10. Home address 1234 S. Broadmoor Ave. (Street and number), West Covina (City or town), California (State) 91790
11. Occupation and division Special Agent, FBI, Los Angeles (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? Yes If not, what work? NA
13. Total length of service with the Government as a civilian? 20½ years
14. How long at present work in this establishment? 16½ years
15. Dates of other injuries None**********
16. Rate of pay on date of injury, $22,999 per annum { and subsistence valued at $dna*** per dna*** / and quarters valued at $dna*** per *****
17. Employee begins work at 8:15 A m. (Hour, a. m. or p. m.) 18. Regular day's work ends 5:00 P m. (Hour, a. m. or p. m.)
19. Hours worked per day eight********* 20. Days paid per week Five*********

The injury

21. Place where injury occurred [redacted] b6 b7C in the Los Angeles Field Division. (Give exact location, as name or number of building and division, etc.)
22. Date of injury December 17, 1971; day of week Friday; hour of day 10 A m. (a. m. or p. m.)
23. Date employee stopped work none, 19____; day of week none; hour of day none m. (a. m. or p. m.)
24. Date employee's pay stopped none, 19____; day of week none; hour of day none m. (a. m. or p. m.)
25. Has employee returned to work? dna********** (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave He was not absent.********** (Give exact dates)
(b) Sick leave He continued on with his duties and to b6
(c) Any other reason no time off from work********** (Give exact dates) b7C
27. Describe in full how injury occurred He entered the residence at [redacted], to interview Mrs. Gloria May Mc Cann on official business. She had the dog restrained on a leash. As he bent down to pat the dog on the head the dog bit him on forefinger and large finger of left hand.
28. State part of body injured and nature and extent of injury Breakage of skin and laceration on forefinger and large fingers of left hand.**********
29. Did injury cause loss of any member or part of member? no If so, describe exactly dna**********
30. Was employee injured while in performance of duty? Yes If not, or in doubt, give detailed statement ***
dna**********
****
31. Was injury caused by:
(a) Willful misconduct of the employee? no (b) Intention of employee to bring about injury or death of himself or another? no (c) Employee's intoxication? no**********
(If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)
32. Was written notice of injury given within 48 hours? Yes If not, did immediate superior have actual knowledge of injury? dna**********
(Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)
33. Names and addresses of witnesses to injury Mrs. Gloria May Mc Cann, [redacted] b6 [redacted] b7C
****
(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)
34. Was injury caused by a third party other than a Government employee or agency? yes********* If so, has employee been instructed in procedure under the Bureau's regulations? **********
(A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case Dr. Sam Cooper, 166 S. Alvarado, Los Angeles, California
36. How soon after injury? Within 2 hours.
37. To what hospital sent? He was not sent to the hospital********** Location **********
38. Name and address of physician now attending case Same as above**********

Signed this 17th day of December, 1971
at FBI, Los Angeles, California

WESLEY G. GRAPP
(Signature of reporting officer)
Special Agent in Charge
(Title)

C. A. 2
December 1961

(OVER)

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what h knows about it and when and by whom the information was given him.]

Signed this _____ day of _____, 19____

_____
(Signature of witness)

Signed this _____ day of _____, 19____

_____
(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that _____ was given first-aid treatment, or examined
(Name of employee)
on _____, 19____, at _____ m., and _____ disabled for work. Probable length of
(Was or was not)
disability will be _____ In my opinion disability _____ due to injury
(Was or was not)
on _____, 19____

Nature of injury as found on examination _____

Hospitalized _____ Will return for further treatment _____

Discharged _____ Other disposition _____

Remarks _____

Signed this _____ day of _____, 19____

at _____

_____
(Signature of medical officer)

_____
(Title)

U.S. GOVERNMENT PRINTING OFFICE: 1964—O-734-915

PLEASE DO NOT MUTILATE THIS MATERIAL IN ANY WAY

Merton R. Anderson

Name

Material sent to

[X] BEC [ ] FILE

12-27-71

Date

3/rgs

RGS

3-518 (2-7-62)

ENCLOSURE

3-451 (Rev. 2-29-68)

January 5, 1972

Bureau of Employees' Compensation
United States Department of Labor
Box 36022
450 Golden Gate Avenue
San Francisco, California 94102

Your File No.
Date of Injury **December 17, 1971**

Merton R. Anderson
(Name)

Gentlemen:

☐ Reference is made to your letter dated _____.

☐ Enclosed are compensation forms and/or other information (indicated below), relative to injuries or diseases incurred by the above-named employee of this Bureau.

☐ CA-1 ☐ CA-2 ☐ ☐ ☐

☐ The desired information is being obtained and will be furnished to your agency within the near future.

☒ The following information is enclosed:

Enclosed, in duplicate, is an unpaid medical bill in the total amount of $15.00.

RECORDED-11

MAILED 23
JAN 5 - 1972
FBI

Very truly yours,

J. Edgar Hoover

John Edgar Hoover
Director

Enc. (2)
1 - Los Angeles
RGS
(3)

JAN 6 1972

MAIL ROOM ☐ TELETYPE UNIT ☐

MC-WRB

FD-277 (Rev. 3-6-63)
OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27
5010-106

UNITED STATES GOVERNMENT

Memorandum

TO : Director, FBI

DATE: 12/30/71

FROM : SAC, Los Angeles

Attention: Personnel Section

SUBJECT: MERTON R. ANDERSON, SA
Compensation Matter

☒ Remylet 12/20/71 .
☐ ReBulet _____ .

☐ Re physical examination _____ .
☐ Dental work was completed on _____ .
☐ Vision has been corrected to _____ . Employee specifically instructed
_____ (date) by _____ (name of person giving instruction) that he can operate a Bureau car only when wearing the necessary glasses.
☐ Results of ☐ chest X ray ☐ patch test ☐ urinalysis ☐ serology were negative.
☐ Enclosed physician's statement indicates he is qualified for strenuous physical exertion and use of firearms.
☒ Enclosed are ☐ paid ☒ unpaid medical bills.
☐ Attached are Bureau of Employees' Compensation forms _____
_____ .
☐ Physical examination reports are enclosed.
☐ Employee is scheduled for physical examination on _____ .
☐ Physical examination report has been reviewed and initialed.
☐ Employee returned to active duty _____ .
☐ Employee's physical condition is _____ .
☐ UACB he is being removed from limited duty.
☐ UACB he is being placed on limited duty.

Remarks:

NOT RECORDED-16

Bulet to BEC 12/30/71 Jmb 1-5-72

1 - Bureau (Encl)
1 - Los Angeles
LLL:lll
(2)

ENCLOSURE

THREE

PHONE 387 4361

State License A-13507

SAM S. COOPER, M. D.
166 SOUTH ALVADARO STREET
LOS ANGELES, CALIFORNIA 90057

Mr. Merton Anderson
1234 Broadmoor
West Covina, Calif. 91790

FOR PROFESSIONAL SERVICES—

Dec. 17, 1971	Dog bite while working Cleansed with solutions & treated	$ 10.00
	Tetanus Toxoid Booster	$ 5.00
		$ 15.00

PLEASE DO NOT MUTILATE THIS MATERIAL IN ANY WAY

Merton R. Anderson
Name

Material sent to
[X] BEC [ ] FILE
1-5-72
Date

3/Rupp

RGS
ENCLOSURE
3-518 (2-7-62)

3-451 (Rev. 2-29-68)

January 7, 1972

Bureau of Employees' Compensation
United States Department of Labor
Box 36022
450 Golden Gate Avenue
San Francisco, California 94102

Your File No.
Date of Injury December 17, 1971

Merton R. Anderson
(Name)

Gentlemen:

☐ Reference is made to your letter dated _____.

☐ Enclosed are compensation forms and/or other information (indicated below), relative to injuries or diseases incurred by the above-named employee of this Bureau.

☐ CA-1 ☐ CA-2 ☐ ☐ ☐

☐ The desired information is being obtained and will be furnished to your agency within the near future.

☐ The following information is enclosed:

Mr. Anderson has advised that he does not intend to take civil action against the third party.

MAILED 8
JAN 7 - 1972
FBI

Very truly yours,

J. Edgar Hoover

John Edgar Hoover
Director

Enc. (0)
1 - Los Angeles
JGC
(3)

MAIL ROOM ☐ TELETYPE UNIT ☐

OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA FPMR (41 CFR) 101-11.6

UNITED STATES GOVERNMENT

Memorandum

TO : DIRECTOR, FBI DATE: 1/4/72

FROM : SAC, LOS ANGELES

SUBJECT: MERTON R. ANDERSON, SA
COMPENSATION MATTER

Re Bureau letter to the Bureau of Employees' Compensation 12/27/71, with instructions for Los Angeles.

SA ANDERSON has advised he plans no civil action in this matter and will not sign a release without appropriate prior approval.

UACB the Bureau will not be advised every 60 days as SA ANDERSON's injury has healed without complication to date.

Let to BEC
JG
1-7-72

67-241451-137

REC-14

7 JAN 10 1972

2 - Bureau
1 - Los Angeles
(67-16143)
WRT:dek
(3)

5010-108

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 3331
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	4/4/72

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	21	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife - Lois Anderson Same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

REC'D 241451-739

ENCLOSURE

(Continue in item 73)

44. DENTAL *(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)*

0 — Restorable teeth; I — Non-restorable teeth; X — Missing teeth; (X) — Replaced by dentures; (X) — Fixed Partial dentures

RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LEFT
		X	X		I	I	I					0	X				

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.004	46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	Negative	D. MICROSCOPIC: 0-1 Wbc's
C. SUGAR	Negative	USPHS, OPC, SAN PEDRO, CA.# 76 19 CHEST X-RAY: Normal Chest

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL: Non-Reactive	See#73	-	HEMATOLOGY: Wbc. 7,500; Hemoglobin - 16.5.

88-116

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 8"	165.	Brn-Grey	Grey	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A. SITTING	SYS. 128 DIAS. 82	B. RECUMBENT	SYS. DIAS.	C. STANDING (3 min.)	SYS. DIAS.	A. SITTING 76	B. AFTER EXERCISE 96	C. 2 MIN. AFTER 76	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 16 CORR. TO 20/	BY S. CX	J8 CORR. TO J1 BY Jones
LEFT 20/ 16 CORR. TO 20/	BY S. CX	J8 CORR. TO J1 BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	Ol Plates OK.		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING		71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15 SV 20 /15			250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15 SV 20 /15		RIGHT									
		LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

No. 48 - Photocopy of EKG attached St-T abnormalities

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE					
P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
GREG SUPER, M.D., SURGEON (R)	G. Super, MD
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR ~~PHYSICIAN~~ (*Indicate which*) DR. STINER, D.D.S.	SIGNATURE R. A. Stiner D.D.S.
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

* U. S. GOVERNMENT PRINTING OFFICE : 1969 O—352-273 (49J)

FD-300 (Rev. 3-27-69)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	62	69
4	11	65	72
8	14	67	76
	17	68	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Not required unless examinee is over 35 years of age or examination indicates such is desirable.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Male Employees and Male Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

2. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

3. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

Desirable Weight Ranges for Males

Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 125	123 - 135	131 - 148
5' 5"	120 - 129	126 - 139	134 - 152
5'6"	124 - 133	130 - 143	138 - 157
5'7"	128 - 137	134 - 148	143 - 162
5'8"	132 - 141	138 - 152	147 - 166
5'9"	136 - 146	142 - 156	151 - 170
5'10"	140 - 150	146 - 161	155 - 175
5'11"	144 - 154	150 - 166	160 - 180
6'	148 - 158	154 - 171	164 - 185
6'1"	152 - 163	158 - 176	169 - 190
6'2"	156 - 167	163 - 181	174 - 195
6'3"	160 - 171	168 - 186	178 - 200
6'4"	169 - 180	178 - 196	188 - 210
6'5"	174 - 185	182 - 202	192 - 216

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds

☐ gain _____ pounds

Remarks: _____

C. Cooper, MD
Signature of Medical Examiner

4/4/72
Date

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 3331

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	3/30/73

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	22	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	Wife -Lois Anderson Same address

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

FILING

67-241451-141
Searched _____ Numbered
4 APR 11 1975 20

ENCLOSURE

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

0 1 2 3 32 31 30 Restorable teeth
/ 1 2 3 32 31 30 Non-restorable teeth
x 1 2 3 32 31 30 Missing teeth
x x x 1 2 3 32 31 30 x x x Replaced by dentures
(x) 1 2 3 32 31 30 (x) Fixed Partial dentures

RIGHT																	LEFT
	0							x									
	1	2	3		5	6		8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
												x	x	x	x	x	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

P/P present

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.005	46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN: Negative	D. MICROSCOPIC: 0-1 wbc. Rare epi cells	USPHS, OPC, SAN PEDRO, CA # 76 19 CHEST X-RAY: Normal Chest
C. SUGAR: Negative		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL: Non-Reactive	See #73		Hematology Wbc. 6,700; Hemoglobin - 15.5.

42

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MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5-8	167 1/2	Brown	Grey	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A. SITTING	SYS. 138 / DIAS. 78	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						72	84	76		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 16 CORR. TO 20/	BY S. CX	J7 CORR. TO J1 BY glasses
LEFT 20/ 16 CORR. TO 20/	BY S. CX	J7 CORR. TO J1 BY glasses

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	P-L plates OK.		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING		71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15	SV 20 /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15	SV 20 /15	RIGHT									
		LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

No. 48 - Photocopy of EKG attached ST-T abnormality Otherwise WNL

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE					
P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
[redacted], M.D., S.A. SURGEON (E)	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR ~~PHYSICIAN~~ (*Indicate which*) DR. SMITH, D.D.S.	SIGNATURE D. Smith (E)
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

* U. S. GOVERNMENT PRINTING OFFICE : 1969 O—352-273 (49J)

FD-300 (Rev. 8-28-72)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	62	69
4	11	65	72
8	14	67	76
	17	68	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee ☑ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☑ No ☐ Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

☑ No ☐ Yes If "yes" please specify defects. _____

2. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☑ No
If recommendation is based on a factor other than above standard, indicate basis _____

67-241451-141

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☐ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____

F H Bagby M D
Signature of Medical Examiner

3-30-73
Date

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 3331

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	3/27/74

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	23	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	b6 b7C

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U S PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

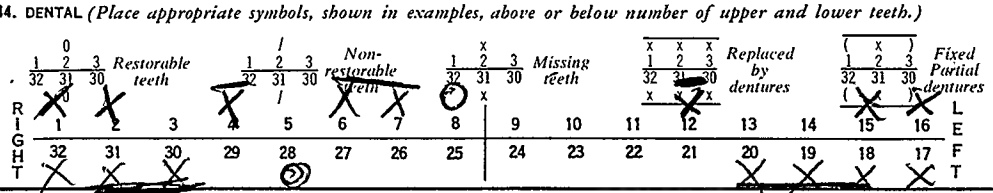
NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

[redacted] 4 51-146

REC-135 9 APR 17 1974 b6 b7C

(Continued in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)



REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.020		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN neg	D. MICROSCOPIC WBC-0-1	USPHS OPC San Pedro,Ca. SP# 76 19 see #73 4-1-74
C. SUGAR neg		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDR:-non reactive	see#73	----	HEMA:HGB-15.1/WBC-7,000

88-116

29

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 8½"	170 ¼	Brown Grey	Hazel or Brown	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.2

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A. SITTING	SYS. 132 DIAS. 92	B. RECUMBENT	SYS. DIAS.	C. STANDING (3 min.)	SYS. DIAS.	A. SITTING 64	B. AFTER EXERCISE 84	C. 2 MIN. AFTER 60	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 16 CORR. TO 20/	BY S. CX	J4 CORR. TO J1 BY glasses
LEFT 20/ 16 CORR. TO 20/	BY S. CX	J7 CORR. TO J2 BY glasses

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION RIGHT	LEFT	64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
		P.I plates OK.		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV 15 /15 SV 20 /15

LEFT WV 15 /15 SV 20 /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

Photocopies of EKG & X-ray attached

Chest X-ray: Normal chest
EKG: Sinus arrhthmia. Few APCs

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

M Eyler

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☑ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

[redacted] b6 b7C

81. TYPED OR PRINTED NAME OF DENTIST ~~OR PHYSICIAN~~ (*Indicate which*) — SIGNATURE

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY — NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1969 O—340-457 (49J)

FD-300 (Rev. 8-28-72)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	62	69
4	11	65	72
8	14	67	76
	17	68	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee ☐ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☐ No ☐ Yes If "yes" please specify defects. _____

_____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

_____

2. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☐ No
If recommendation is based on a factor other than above standard, indicate basis _____ b6 _____
_____ b7C _____

_____

[redacted]

DESIRABLE WEIGHT RANGES

REC'D ADMIN. DIV. APR 30 2 57 PM 1974

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is ☐ small ☐ medium ☒ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

b6
b7C

Date

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 3331
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	3/31/75

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Cauc	3½	24	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	b6 b7C

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U. S. PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

REC-134

b6
b7C

17 1975

(Co 13)

44. DENTAL *(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)*

Restorable teeth · Non-restorable teeth · Missing teeth · Replaced by dentures · Fixed Partial dentures

RIGHT 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES: Wears P/P

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.010		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN neg	D. MICROSCOPIC	USPMS OPC San Pedro,Ca. SP#76 19
C. SUGAR neg	ess. neg.	see #73 3-31-75

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL:non reactive	see#73	-----	HEMA:HGB-16.6/WBC-7,500

2 APR 21 1975

88-116

APR 21 1975

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 8"	169	Br. Grey	Hazel	☐ SLENDER ☐ MEDIUM ☒ HEAVY ☐ OBESE	98

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A. SITTING	SYS. 125 / DIAS. 80	B. RECUMBENT	SYS. / DIAS.	C. STANDING (*3 min.*)	SYS. / DIAS.	A. SITTING 72	B. AFTER EXERCISE 92	C. 2 MIN. AFTER 76	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 15 CORR. TO 20/	BY S. CX	J 10 CORR. TO J 1 BY glasses
LEFT 20/ 20 CORR. TO 20/	BY S. CX	J 1 CORR. TO J 1 BY glasses

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	2 Plates Normal		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV 15 /15 SV		20 /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV 15 /15 SV		20 /15	RIGHT									
			LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

None

Photocopies of EKG & X-ray attached

X-ray: Normal chest
EKG: Sinus rhythm normal
Minor ST-T wave changes

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

None except ~~Brown~~ Green eyes

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

None

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY b6 b7C

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79.

80. TYPED OR PRINTED NAME OF PHYSICIAN

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*) SIGN

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY SIGNATURE [illegible] OF ATTACHED SHEETS

GPO: 1971 446-044/15

FD-300 (Rev. 8-28-72)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	62	69
4	11	65	72
8	14	67	76
	17	68	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

71. Audiometer examinations should be afforded whenever possible for all Special Agent applicants and Special Agents. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 15 decibel average in either ear in the conversational speech range (500, 1000, 2000 cycles).

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

2. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

[illegible] 12-24195 1-188

b6
b7C

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is ☐ small ☑ medium ☐ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

b6
b7C

3.31.75
Date

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 3331

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
11000 Wilshire Boulevard Los Angeles, CAlifornia	ANNUAL PHYSICAL	4/26/76

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE — MILITARY	CIVILIAN	10. AGENCY	11. ORGANIZATION UNIT
Male	Cauc	3½	25	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	[redacted] b6 b7C

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U. S. PUBLIC HEALTH, San Pedro, Calif.	***

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

(Check each item in appropriate column; enter "NE" if not evaluated.)

NORMAL		ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

28 — see [illegible]

67- [illegible] - 154

REC-149

Searched ____ Indexed ____
5 JUN 3 1976

[redacted]

ENCLOSURE

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable teeth — Non-restorable teeth — Missing teeth — Replaced by dentures — Fixed Partial dentures

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LEFT

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

~~Upper replaced~~ ~~[illegible]~~

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.014/PH-6		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN neg	D. MICROSCOPIC WBC-0-1/	USPHS OPC San Pedro,CA & SP# 76 19
C. SUGAR neg	EPI-few/BILE-neg	normal chest 4-26-76

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
VDRL:non reactive	see#73	----	HEMA:HGB-14.4/WBC-6,700

88-116

5 JUN 10 1976 55

b6
b7C [redacted]

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 8"	173	Grey Brown	Hazel	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.2

57. BLOOD PRESSURE (*Arm at heart level*) — 58. PULSE (*Arm at heart level*)

A. SITTING	SYS. 134 / DIAS. 70	B. RECUMBENT	SYS. / DIAS.	C. STANDING (5 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						64	80	72.		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 16 CORR. TO 20/	BY S. CX	J4 CORR. TO J1 BY glasses.
LEFT 20/ 16 CORR. TO 20/	BY S. CX	J4 CORR. TO J1 BY glasses

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. [illegible]

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	P-I-plates		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED-LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV 15 /15 SV 20 /15

LEFT WV 15 /15 SV 20 /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT	5	5	10	5		85		70
LEFT	5	5	0	5		30		55

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

None

Photocopies of EKG 7 X-ray EKG: No change WNL

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

None

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

None

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☐ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

b6
b7C

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

B	C	E

79. TY[illegible]

80. TYPED OR PRINTED NAME OF PHYSICIAN

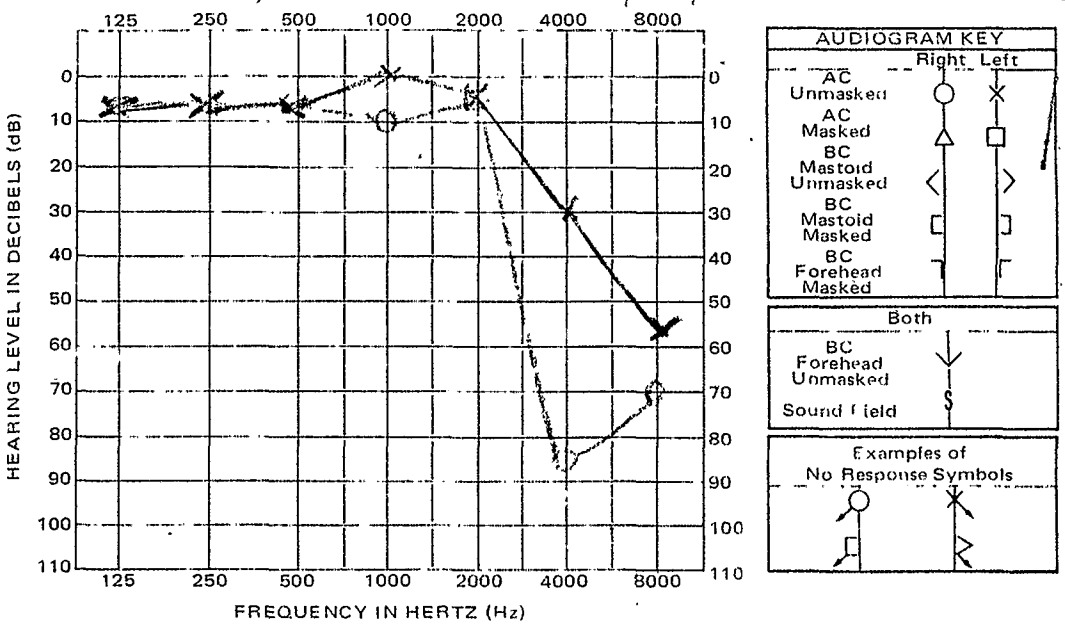
81. TYPED OR PRINTED NAME OF DENTIST O[illegible] (*Indicate which*) — SIGNA[illegible]E

82. TYPED OR PRINTED NAME OF REVIEWING [illegible]ROVING AUTHORITY — SIGNATURE — NUMBER OF ATTACHED SHEETS

GPO: 1971 446-044/15

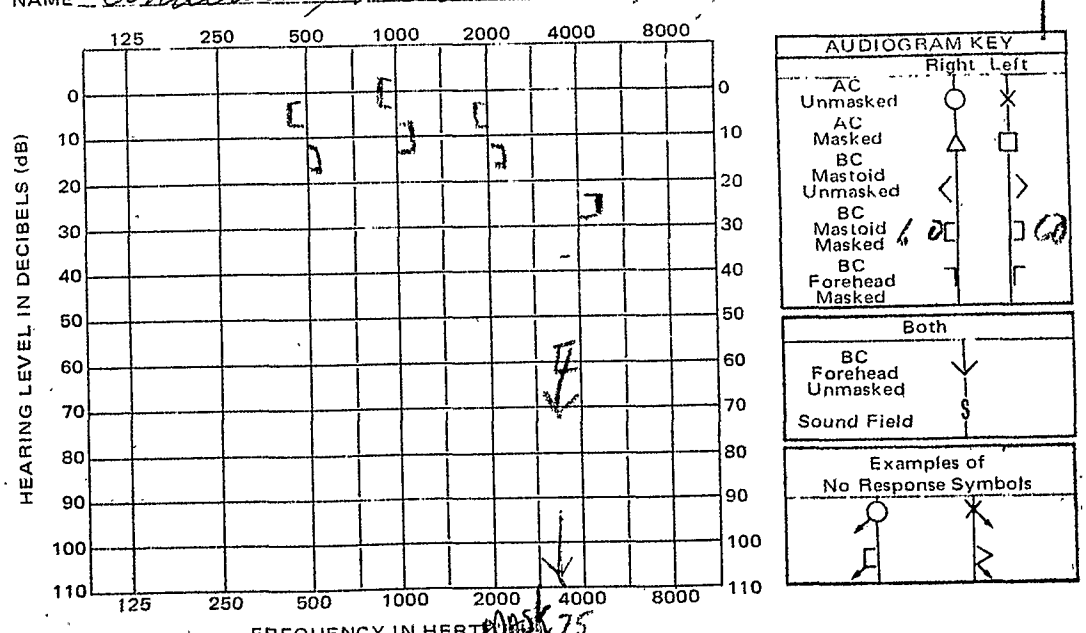
MAICO AUDIOGRAM

NAME Anderson, Merlon DATE 4/26/76 BY [redacted] b6 b7C



MAICO AUDIOGRAM

NAME Anderson, Merlon DATE 4/26/76 BY [redacted]



MASK 75

ENCLOSURE

b6
b7C

FD-300 (Rev. 11-11-75)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	17	67	76
4	11	62	68	
8	14	65	72	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

69. Required for all examinees over 40 years of age.

71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee ☑ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☐ No ☐ Yes If "yes" please specify defects. _____

_____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

☐ No ☐ Yes If "yes" please specify defects. _____

_____

2. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☐ No
If recommendation is based on a factor other than above standard, indicate basis _____

ENCLOSURE

_____

_____

b6
b7C

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'3"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is ☐ small ☐ medium ☐ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☐ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

_____

_____

b6
b7C

4/26/74
Date

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR-101-11.809-3

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 3331

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	4/25/77

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
Male	Cauc	MILITARY 3½	CIVILIAN 26	FBI	***

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
7/21/20	Wisconsin Dells, Wisc.	[redacted] b6 b7C

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
U. S. PUBLIC HEALTH, San Pedro, Ca.	**

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

62-111451-158

REC-144

4 MAY 11 1977

b6
b7C

ENCLOSURE

(Continue item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable teeth (0) · Non-restorable teeth (/) · Missing teeth (X) · Replaced by dentures · Fixed Partial dentures

RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LEFT
UPPER		2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
LOWER	X	X	X											X	X	X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

S/P N. A. P.

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.015		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN neg	D. MICROSCOPIC wbc-rare/epi-rare	USPHS OPC San Pedro,CA SP# 76 19
C. SUGAR neg		normal chest 4-25-77

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
5 MAY 18 1977 VDRL: non reactive	see #73	----	HEMA: HGB-16.1/WBC-6,800

88-116

MAY 17 1977

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 8"	174	Grey Brown	Hazel	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98

57. BLOOD PRESSURE (*Arm at heart level*) **58. PULSE** (*Arm at heart level*)

A. SITTING	SYS. 144 / DIAS. 74	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
						64	78	64		

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 16 CORR. TO 20/	BY S. CX	J 8 CORR. TO J BY glasses
LEFT 20/ 16 CORR. TO 20/	BY S. CX	J 8 CORR. TO J 1 BY glasses

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT	R-G plates OK.		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING

RIGHT WV 15 /15 SV 20 /15

LEFT WV 15 /15 SV 20 /15

71. AUDIOMETER

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT	5	10	10	10		85		55
LEFT	5	5	0	5		30		75

72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)

73. NOTES (*Continued*) **AND SIGNIFICANT OR INTERVAL HISTORY**

photocopies of EKG, Audiogram attached

EKG: Since 4/26/76, no real change

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☒ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN [redacted] SIGNATURE [redacted] b6 b7C

80. TYPED OR PRINTED NAME OF PHYSICIAN SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*) SIGNATURE

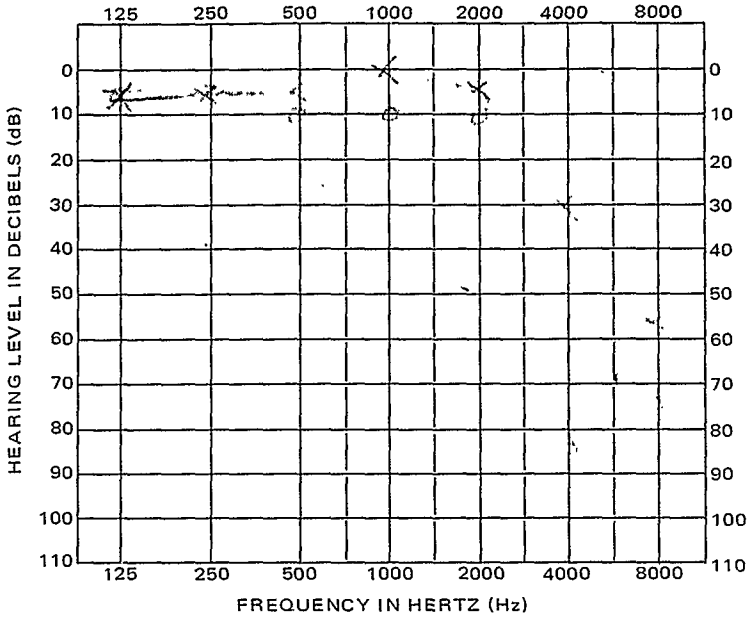
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY SIGNATURE NUMBER OF ATTACHED SHEETS

☆U.S.GPO:1975-0-565-625/58

MAICO AUDIOGRAM

NAME Anderson Merton DATE 4/25/77

b6
b7C



AUDIOGRAM KEY

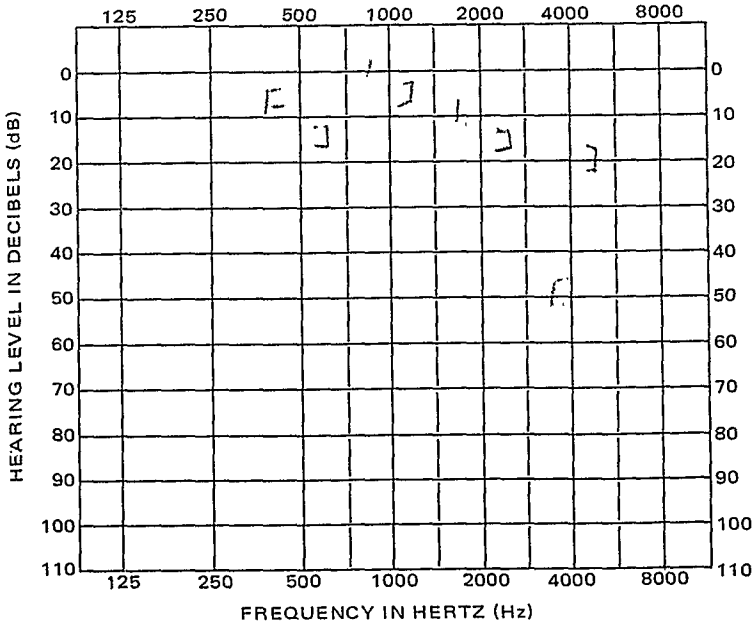
	Right	Left
AC Unmasked	○	×
AC Masked	△	□
BC Mastoid Unmasked	<	>
BC Mastoid Masked	[	]
BC Forehead Masked	⌐	¬

Both	
BC Forehead Unmasked	↓
Sound Field	S

	Left Ear	Right Ear
S.R.T.		
M.C.L.		
T.D.		

MAICO AUDIOGRAM

NAME Anderson Merton DATE 4/25/77



AUDIOGRAM KEY

	Right	Left
AC Unmasked	○	×
AC Masked	△	□
BC Mastoid Unmasked	<	>
BC Mastoid Masked	[	]
BC Forehead Masked	⌐	¬

Both	
BC Forehead Unmasked	↓
Sound Field	S

	Left Ear	Right Ear
S.R.T.		
M.C.L.		
T.D.		

FREQUENCY IN HERTZ (Hz)

b6
b7C

FREQUENCY IN HERTZ (Hz)

FREQUENCY IN HERTZ (Hz)

60-24[illegible]/51-158

FD-300 (Rev. 11-11-75)

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee (Type or print) ANDERSON, (Last) MERTON (First) R. (Middle)

The following portions of the attached examination report form need not be completed:

3	9	17	67	76
4	11	62	68	
8	14	65	72	

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

69. Required for all examinees over 40 years of age.

71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee ☒ is ☐ is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

☒ No ☐ Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

☒ No ☐ Yes If "yes" please specify defects. _____

2. For safe driving of motor vehicles, Civil Service Commission requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? ☐ Yes ☒ No
If recommendation is based on a factor other than above standard, indicate basis _____

ENCLOSURE

FBI/DOJ

b6
b7C

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

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FINANCE &
PERSONNEL DIV.
FBI
MAY 13 1 25 PM 1977

4. Examinee's frame is ☐ small ☒ medium ☐ large

5. Considering above weight table, the examinee's frame, and other individual physical characteristics, I consider his present weight ☒ Satisfactory ☐ Excessive ☐ Deficient

6. Under proper medical supervision, employee should ☐ lose _____ pounds
☐ gain _____ pounds

Remarks: _____

b6
b7C

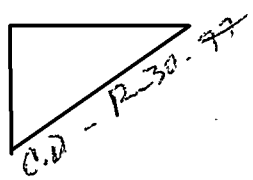
Sign[redacted] Examiner

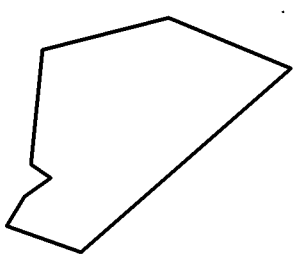
Date

MEDICAL REPORTS

Personnel File of: ANDERSON, MERTON ROWE

Personnel File No. _____





b6
b7C

MRR

Standard Form 520
Rev. August 1954
Promulgated
By Bureau of the Budget
Circular A—32

CLINICAL RECORD | ELECTROCARDIOGRAPHIC RECORD

PREVIOUS ECG ☐ YES ☐ NO

CLINICAL IMPRESSION

MEDICATION

☐ EMERGENCY ☐ BEDSIDE
☐ ROUTINE ☐ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B. P.	SIGNATURE OF WARD PHYSICIAN	DATE
40	Male	Cau	68½	153		D. J. WILLIAMS LT MC USNR	15 Mar 61

RHYTHM: Occasional Supraventricular premature c Sinus Rhythm

AXIS DEVIATION (QRS): Vertical

RATES: AURIC. 61 VENT. 61

INTERVALS: PR .16 QRS .09 QT .44

P WAVES: Biphasic AVL, V1

QRS COMPLEXES: occasional premature beats of Supraventricular origin

RS—T SEGMENT: baseline

T WAVES: upright

UNIPOLAR EXTREMITY LEADS (*Specify*)

PRECORDIAL LEADS (*Specify*)

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

Comparison c Previous tracing indicates no change 4-6-61
EKG Normal

Comparison to previous tracings indicates
atrial premature beats occ 67-5124-5
occ four - A-V, nodal premature beats

WNL

(Continue on reverse)

NO.	SIGNATURE	TITLE	DATE
ECG			

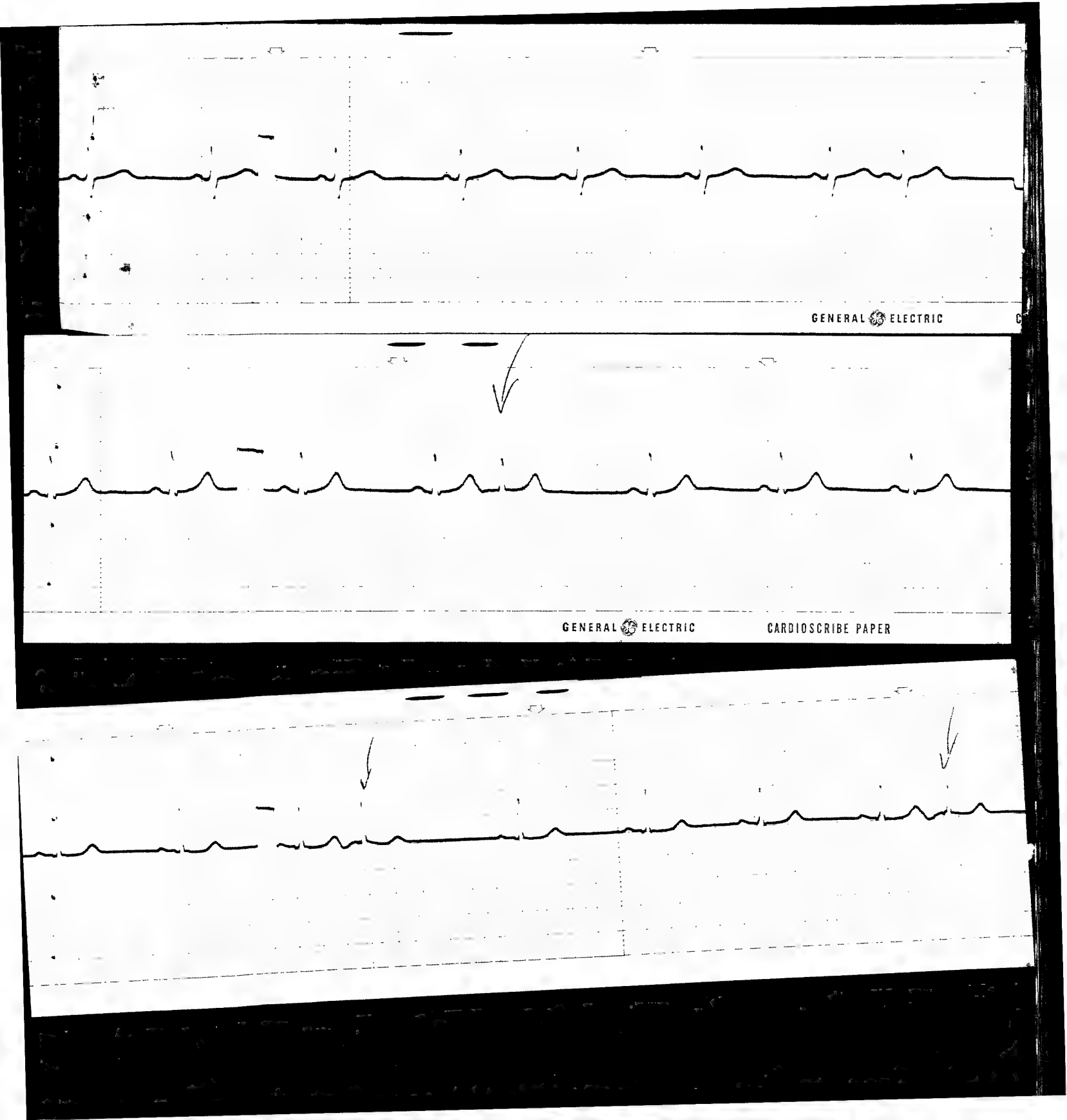
PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

ANDERSON, Merton Roger SA FBI

REGISTER NO. | WARD NO.

ELECTROCARDIOGRAPHIC RECORD
Standard Form 520
(*Attach tracings to S. F. 507*)

U. S. GOVERNMENT PRINTING (1954—O-309813 16—56209-4 †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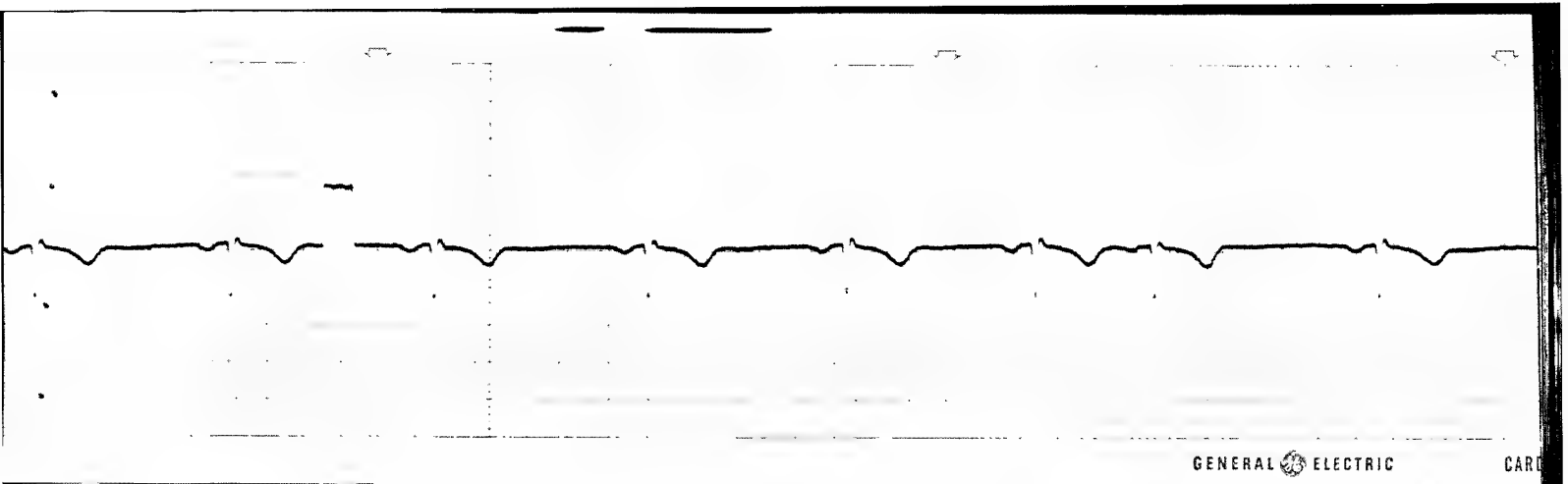
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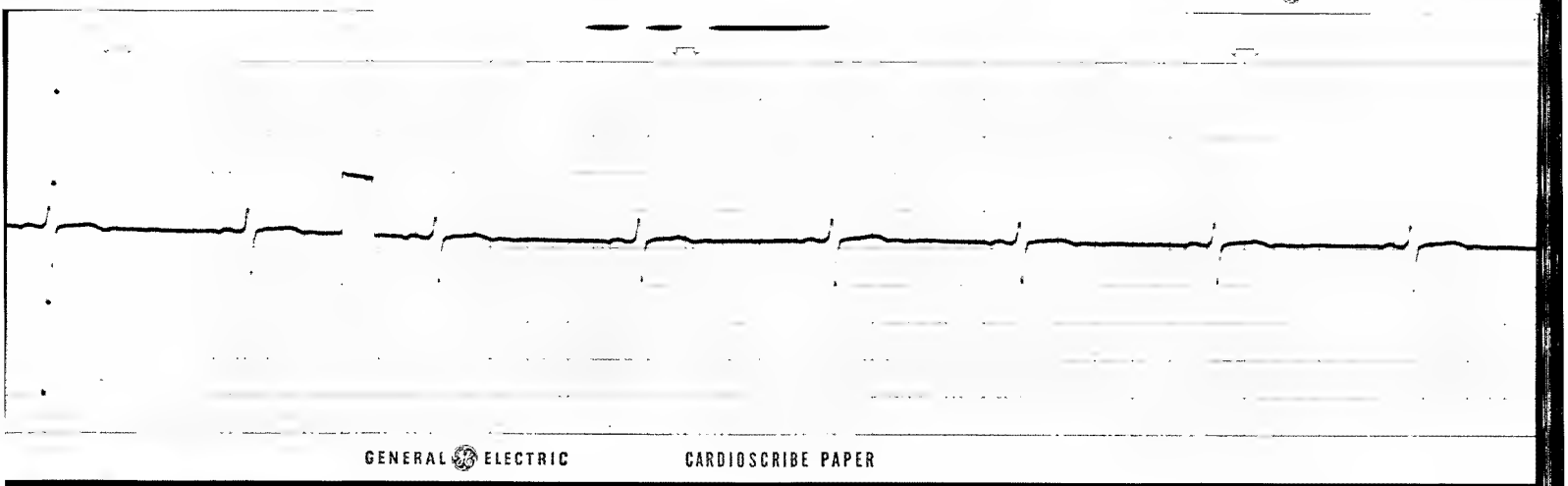
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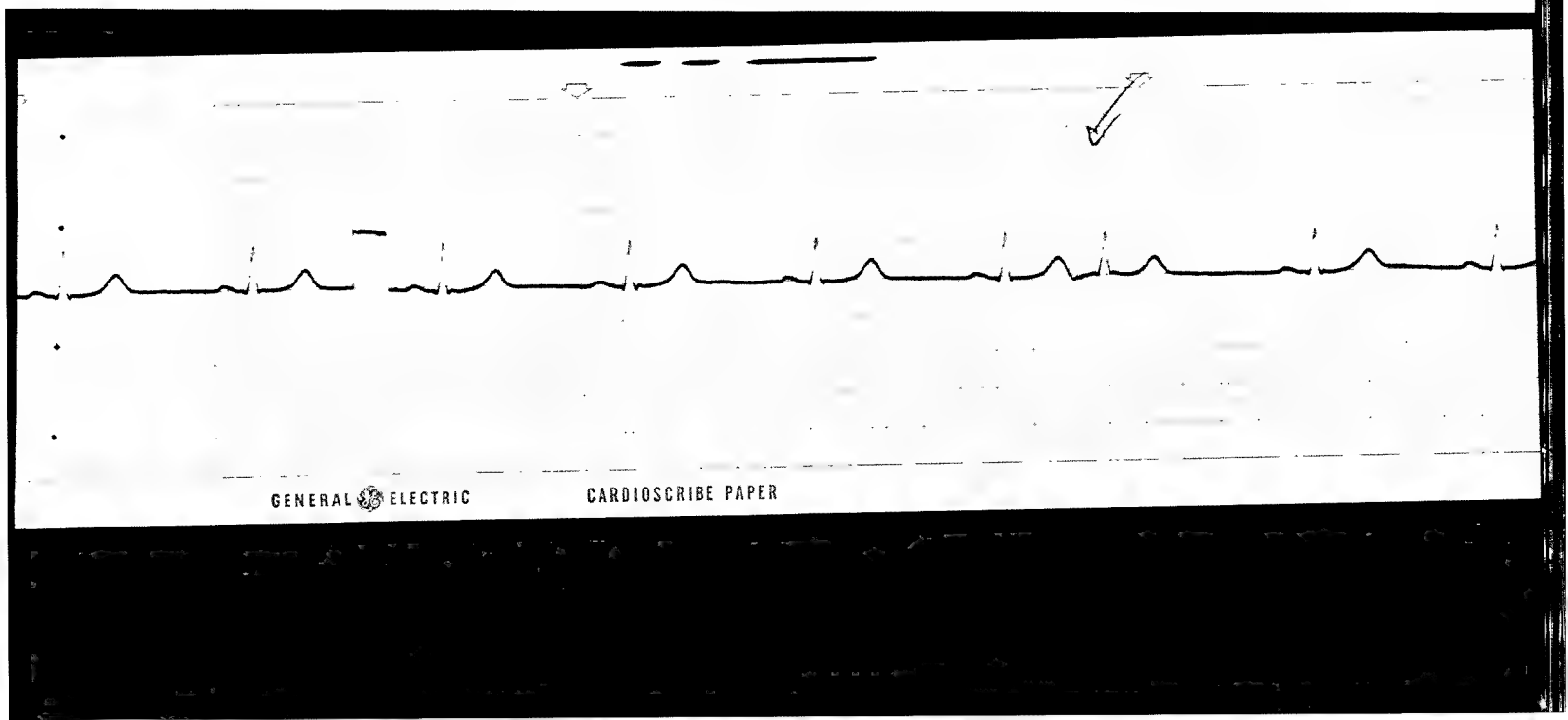
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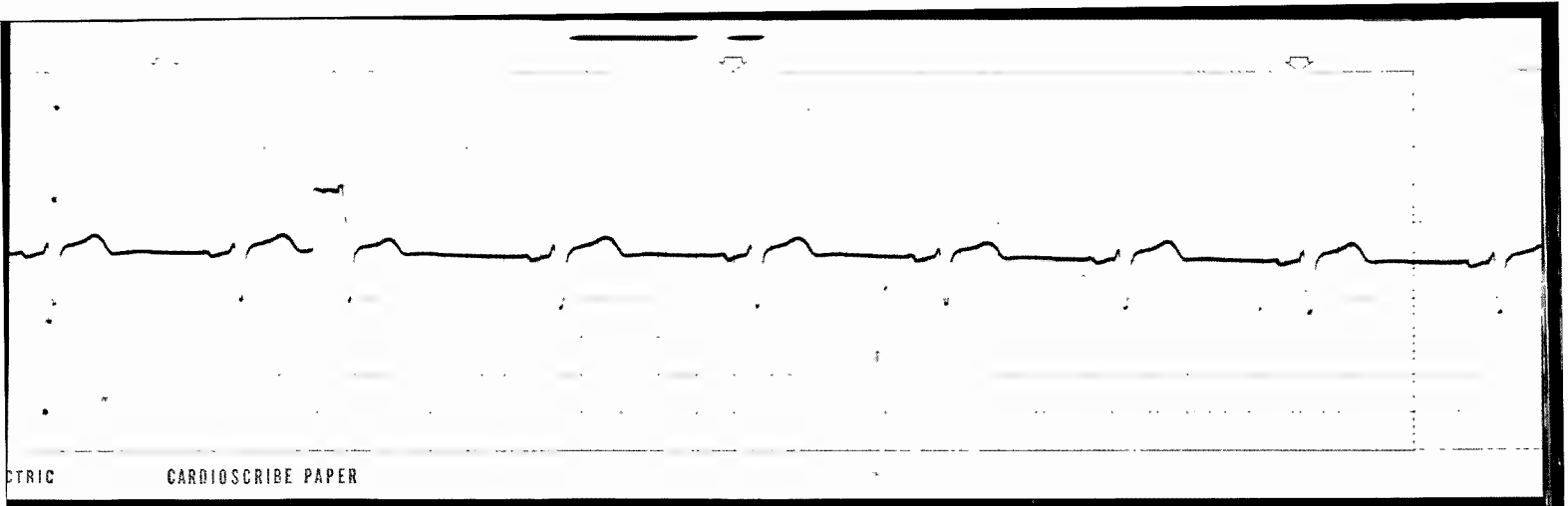
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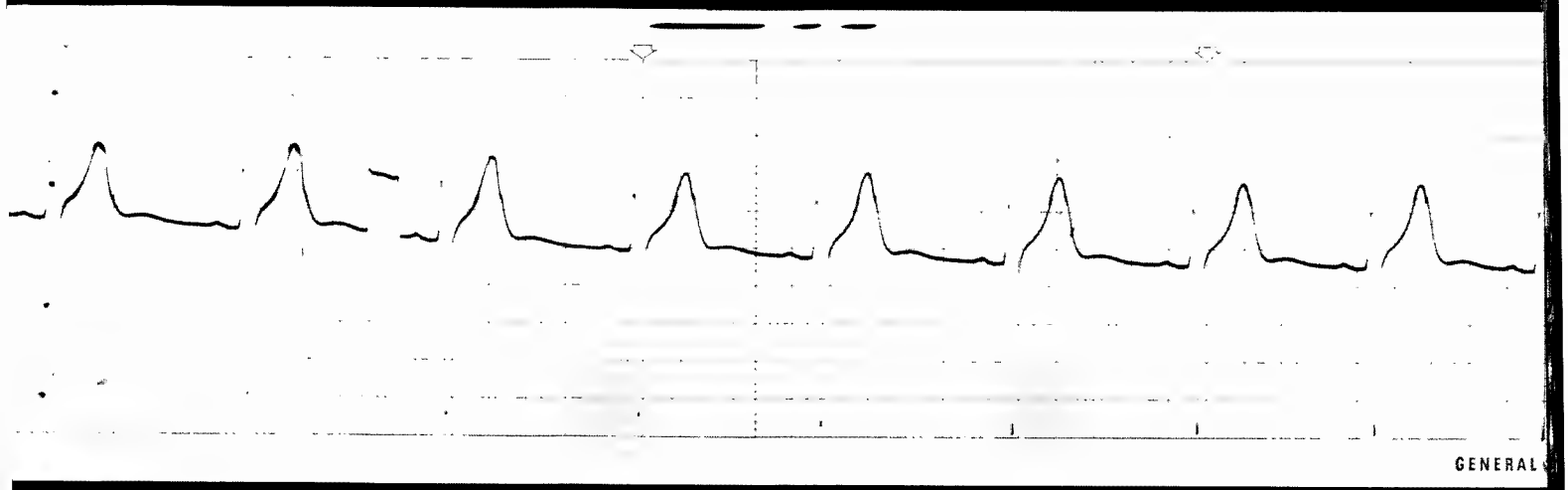
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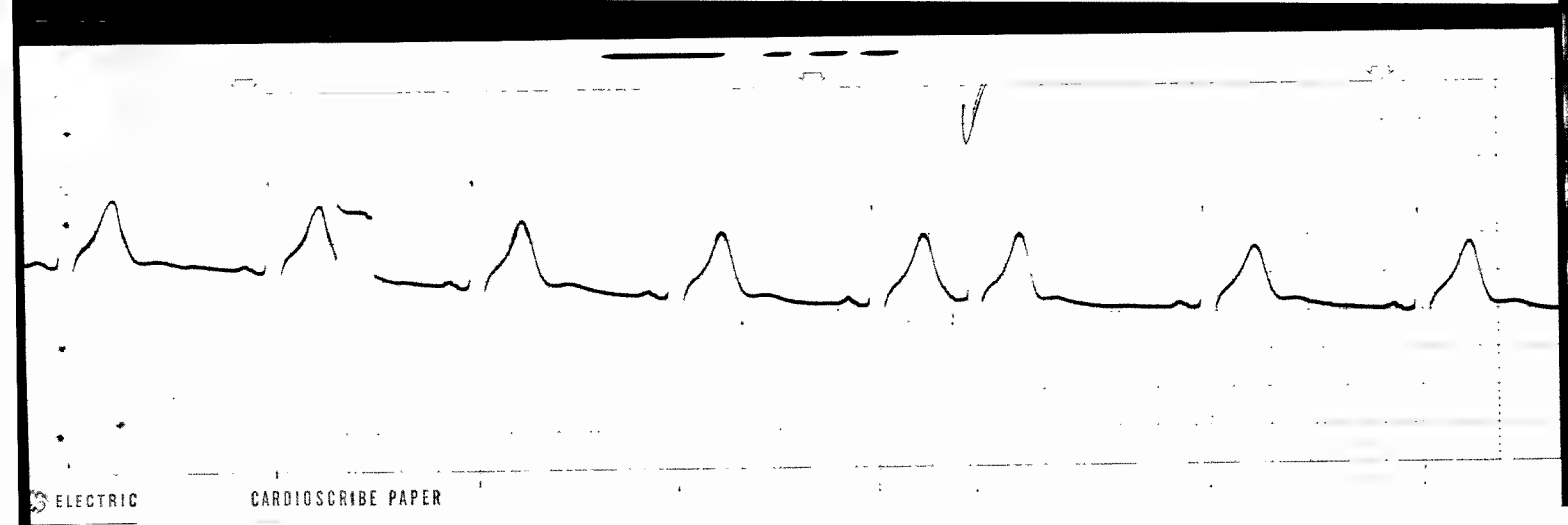
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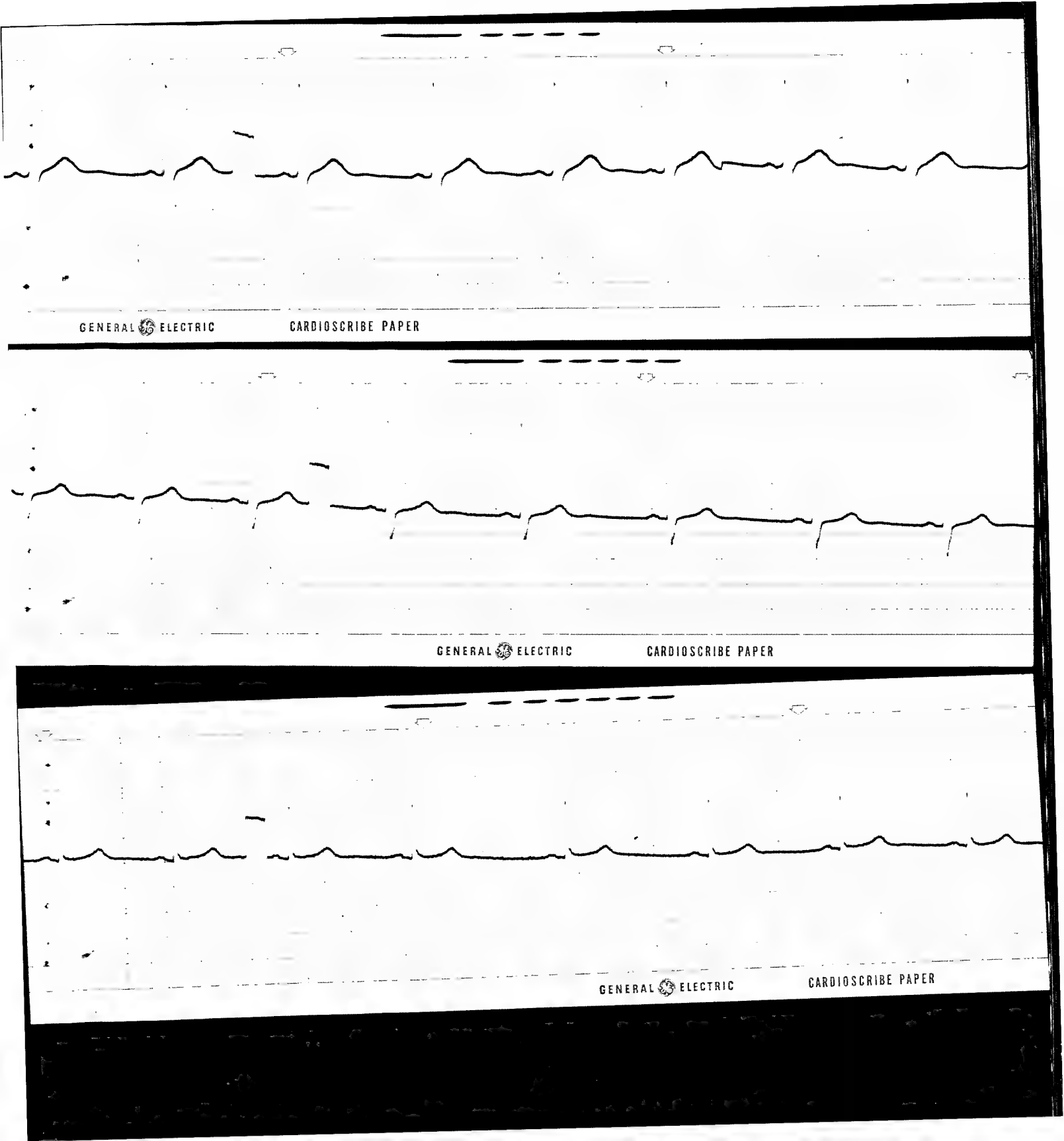
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GENERAL ELECTRIC CARDIOSCRIBE PAPER

Standard Form 520
Promulgated August 1948
By Bureau of the Budget
Circular A—32

CLINICAL RECORD | **ELECTROCARDIOGRAPHIC REPORT**

PREVIOUS ECG ☐ YES ☐ NO

CLINICAL IMPRESSION

MEDICATION

☐ EMERGENCY ☐ BEDSIDE
☐ ROUTINE ☐ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B.P.	SIGNATURE OF WARD PHYSICIAN	DATE
39	M	C	68	154	132/86		3-25-59

RHYTHM
Normal Sinus with Frequent Premature Auricular Systoles

AXIS DEVIATION (QRS)
Vertical Position

RATES
AURIC. 70 VENT. 70/min.

INTERVALS
PR 0.16 QRS 0.07 QT 0.36 sec.

P WAVES
Normal.

QRS COMPLEXES
Prominent R in aVR.

RS—T SEGMENT
ST elevation in V1, V2, V3.

T WAVES low amplitude I, V5, V6
Inverted in aVL.

PRECORDIAL LEADS (Specify)
ST-T changes as above.

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

ST-T changes in I, V leads are abnormal, non-specific.
Past history and previous tracings would be helpful in interpretation.
A Definitely Abnormal Tracing.

NO. ECG	SIGNATURE	TITLE	DATE
	Dean L. Hudson, M.D.		27 Mar '59

Compared to tracing of 3/20/58; T waves are of lower amplitude in I, V5. R wave is more prominent. ST elevations in V1, V2, V3 were not present in 3/20/58. These changes are non-specific, but are abnormal.
D L Hudson, MD

MOUNT TRACINGS HERE

(Continue on reverse)

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME
A[illegible], Norton Roger

REGISTER NO.
SA [illegible]

WARD NO.

(NAME OF HOSPITAL OR OTHER MEDICAL FACILITY)

ELECTROCARDIOGRAPHIC REPORT
Standard Form 520

U. S. GOVERNMENT PRINTING OFFICE [illegible]-60200-2

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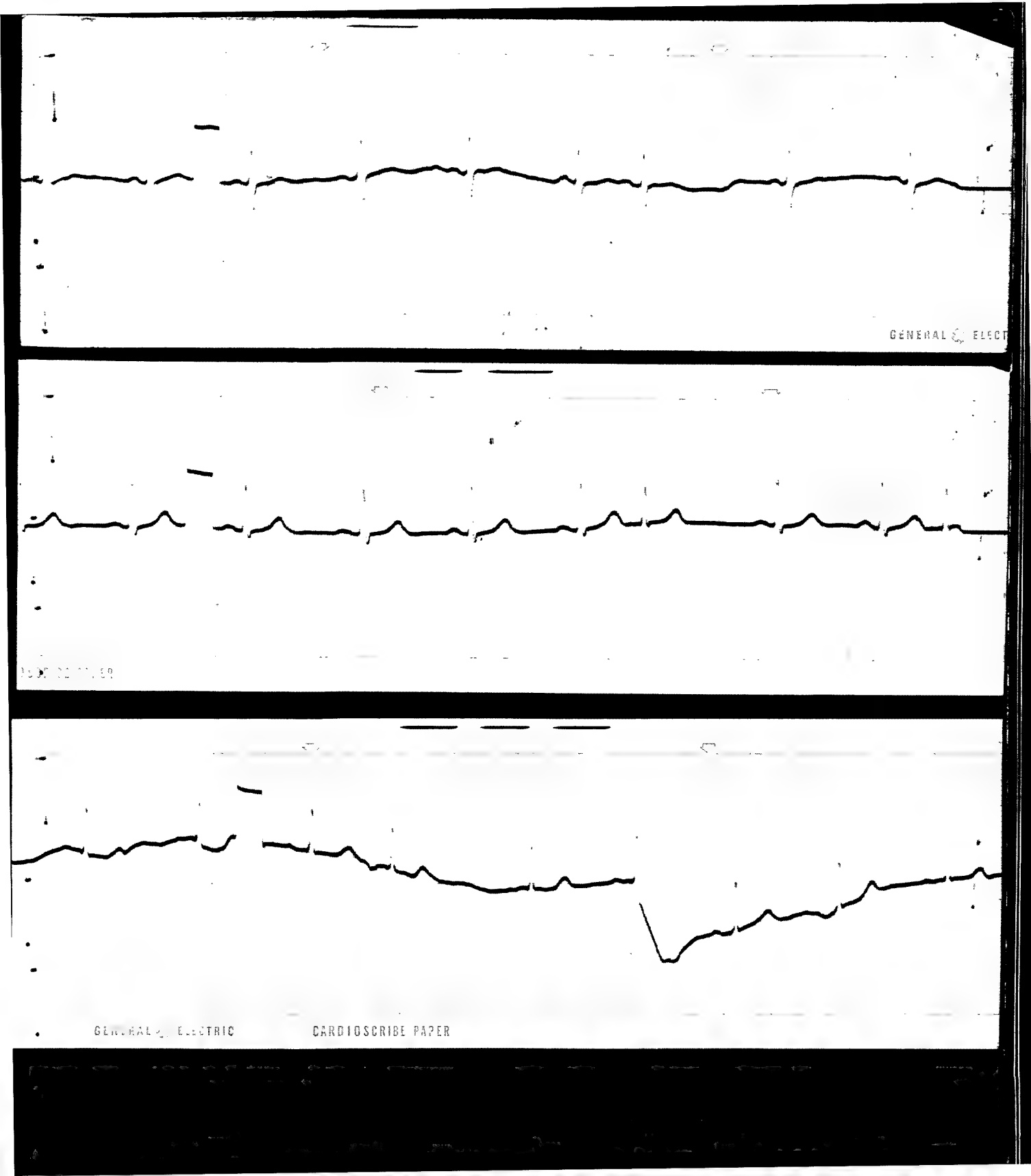
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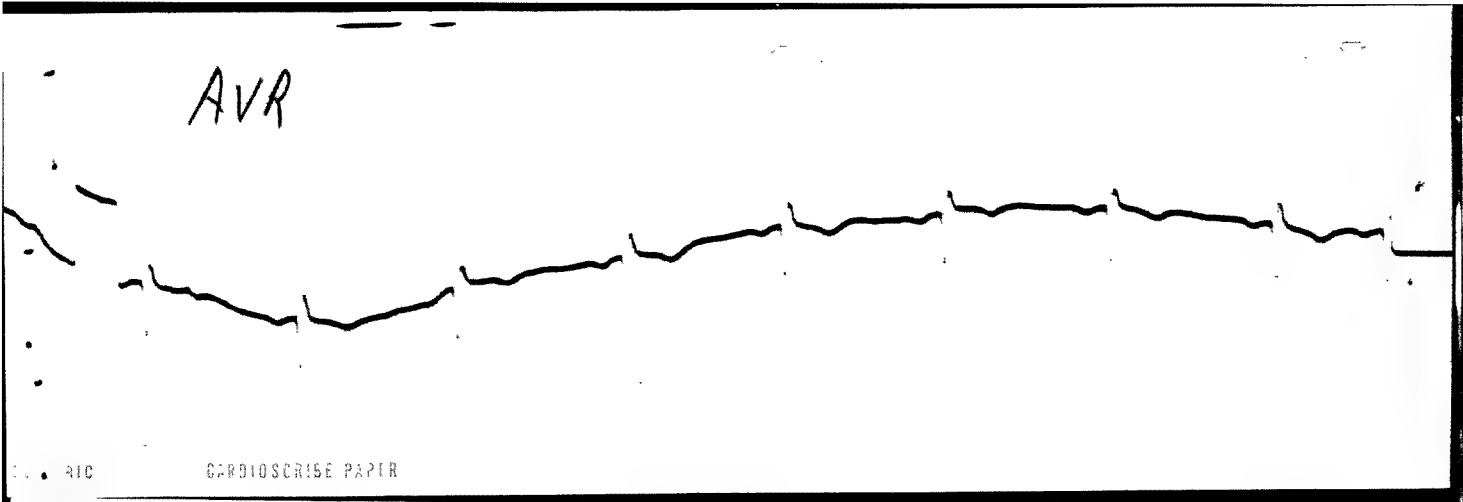
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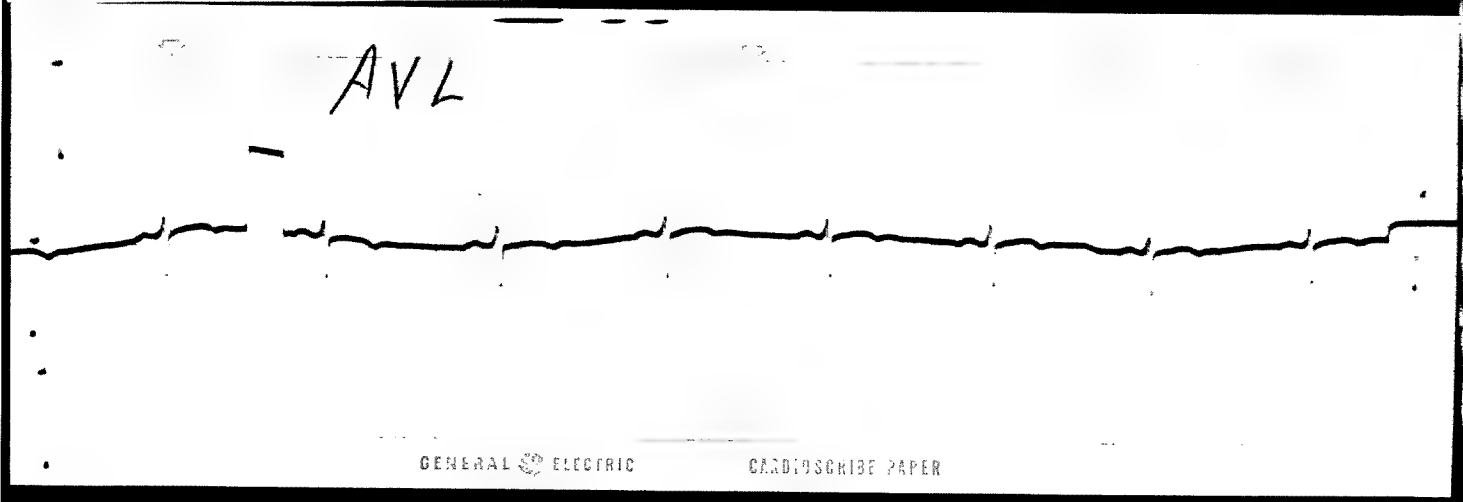
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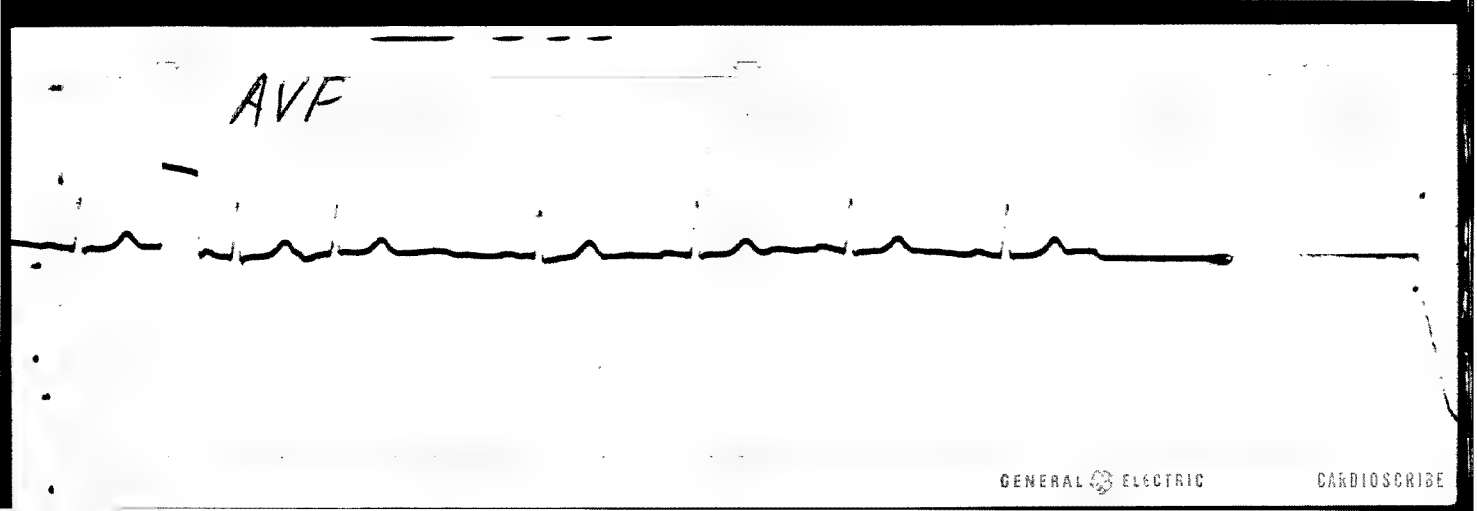
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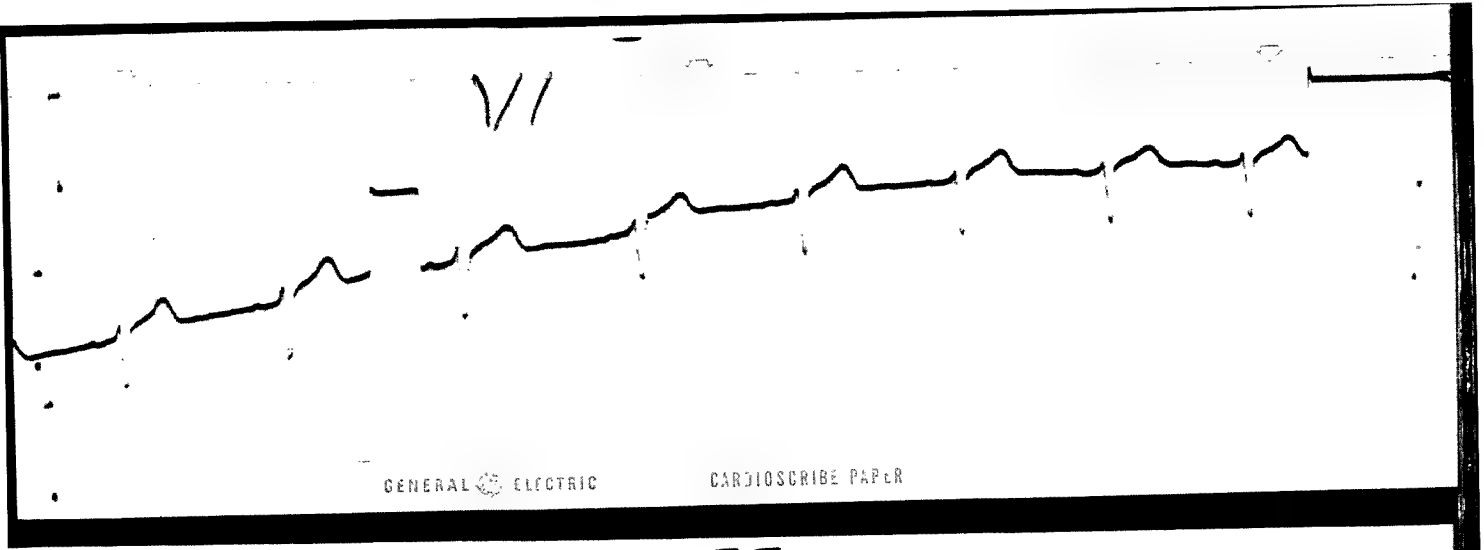
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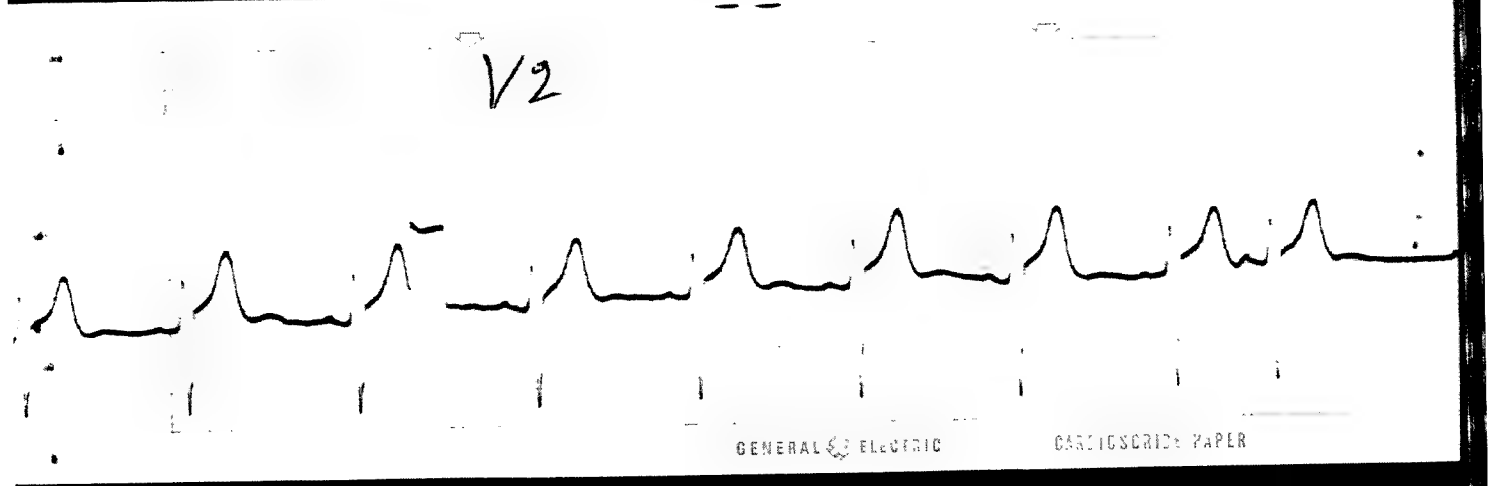
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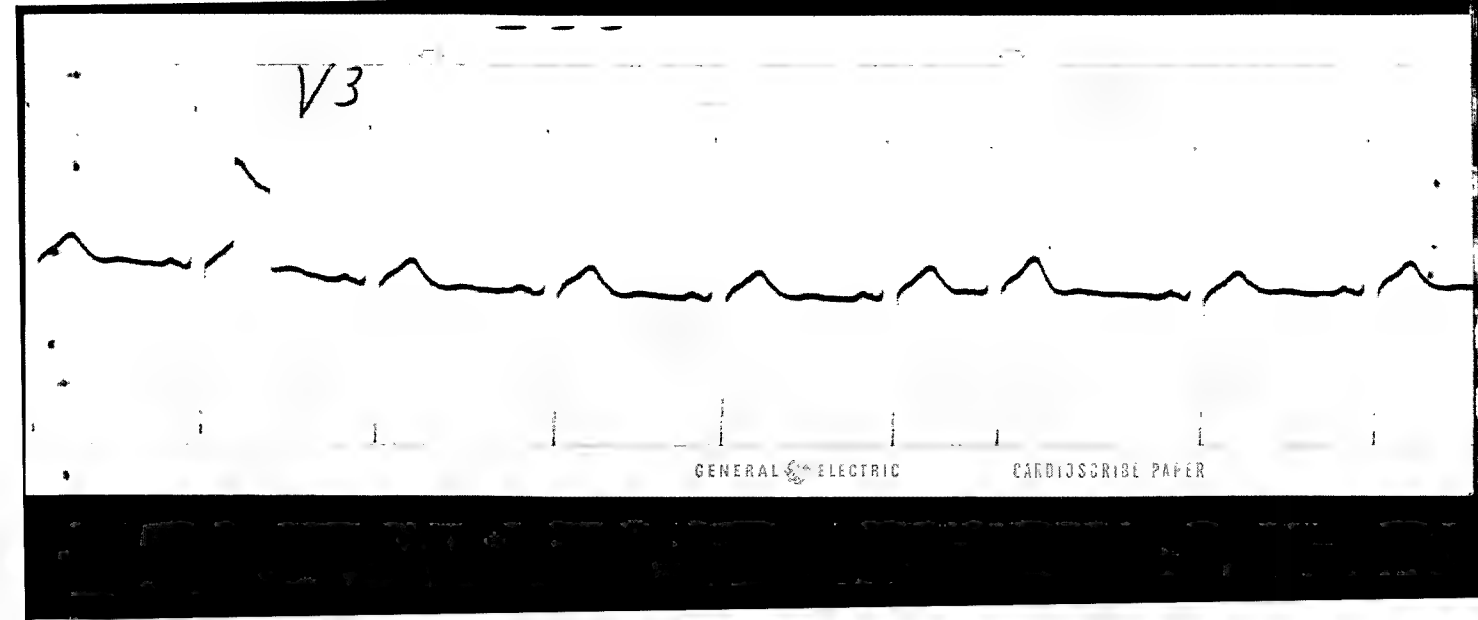
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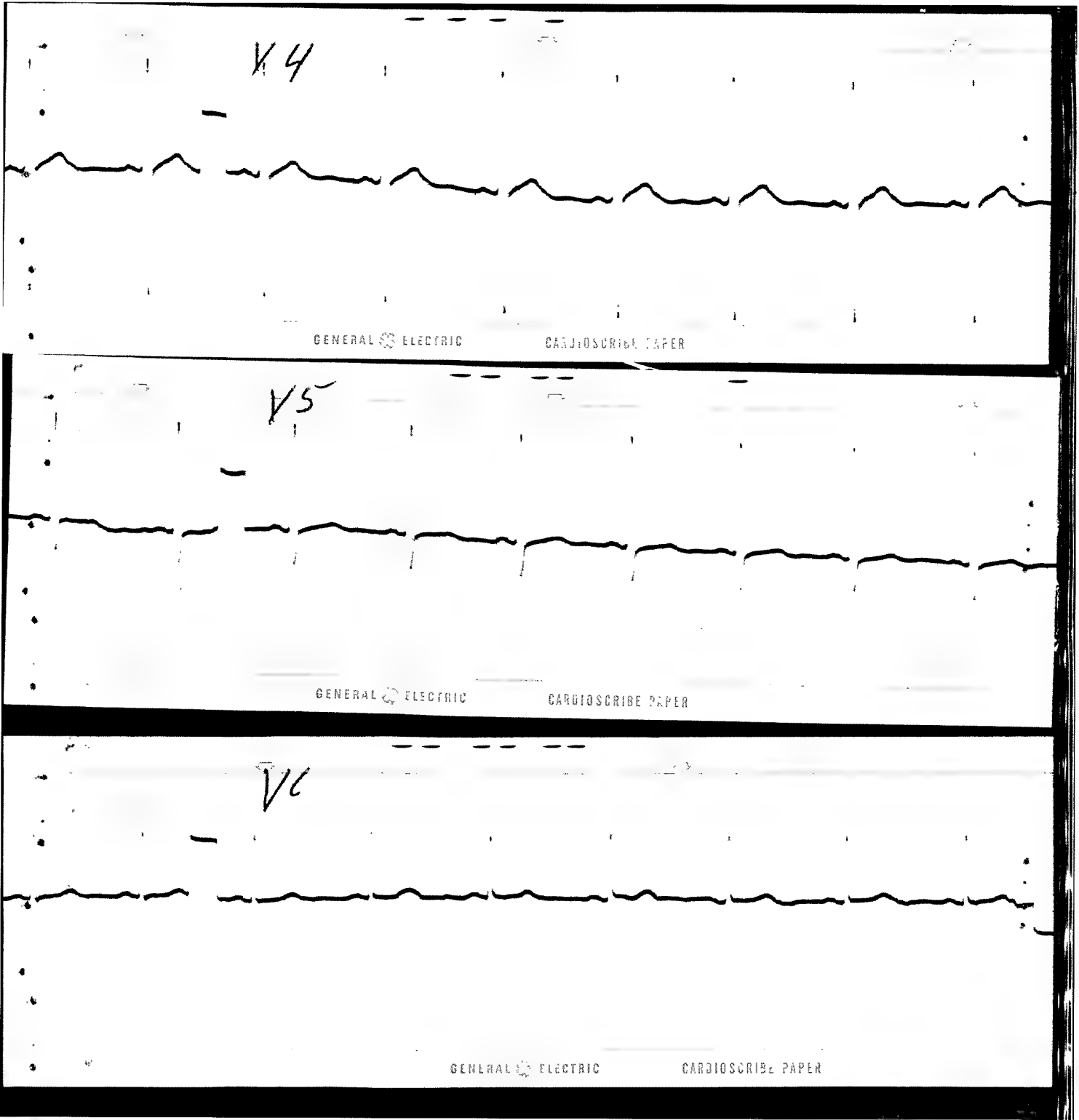
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GENERAL ELECTRIC CARDIOSCRIBE PAPER
V5
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V6
GENERAL ELECTRIC CARDIOSCRIBE PAPER

Standard Form 520
Promulgated August 1948
By Bureau of the Budget
Circular A—32

CLINICAL RECORD — ELECTROCARDIOGRAPHIC REPORT

PREVIOUS ECG ☐ YES ☐ NO

CLINICAL IMPRESSION

MEDICATION

☐ EMERGENCY ☐ BEDSIDE
☐ ROUTINE ☐ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B. P.	SIGNATURE OF WARD PHYSICIAN	DATE
37	M	C	68	156	108/82		3-20-58

RHYTHM: Occasional P.A.C.'s.

AXIS DEVIATION (QRS): Vertical

RATES — AURIC. VENT.

INTERVALS — PR QRS QT

P WAVES

QRS COMPLEXES

RS—T SEGMENT

T WAVES

PRECORDIAL LEADS *(Specify)*

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

Within normal limits

NO. ECG	SIGNATURE	TITLE	DATE
	John R. Lee	MD	3-20-58

MOUNT TRACINGS HERE

(Continue on reverse)

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME	REGISTER NO.	WARD NO.
ANDERSON, Merton R.	SA	FBI

USNAS, SEATTLE, WASH.
(NAME OF HOSPITAL OR OTHER MEDICAL FACILITY)

ELECTROCARDIOGRAPHIC REPORT
Standard Form 520

U. S. GOVERNMENT PRINTING OFFICE 16-56209-2

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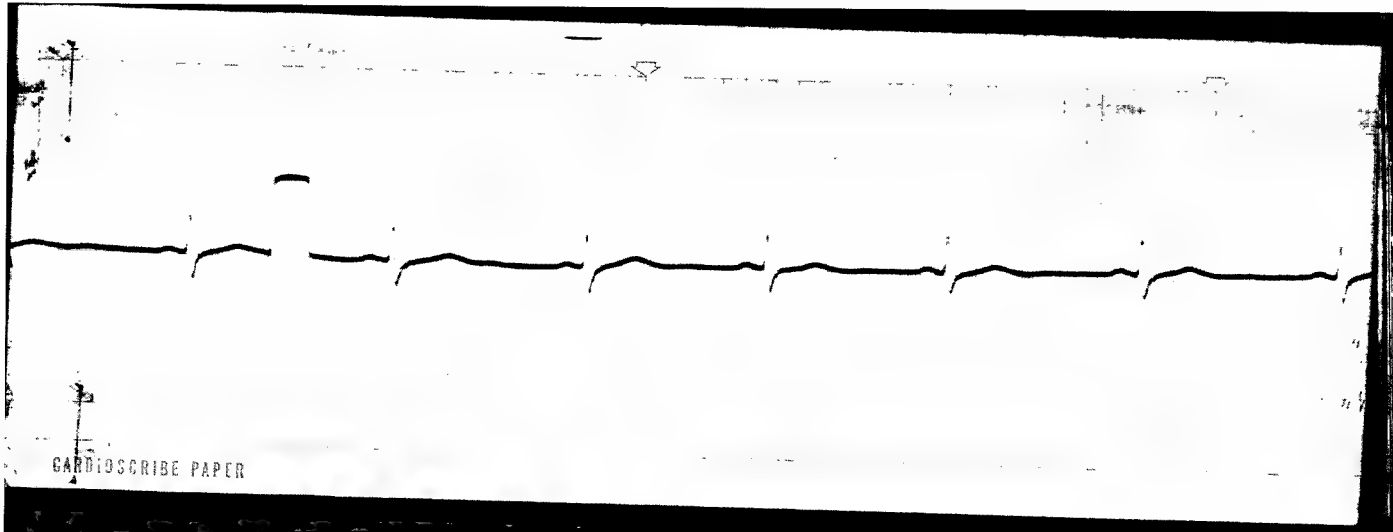
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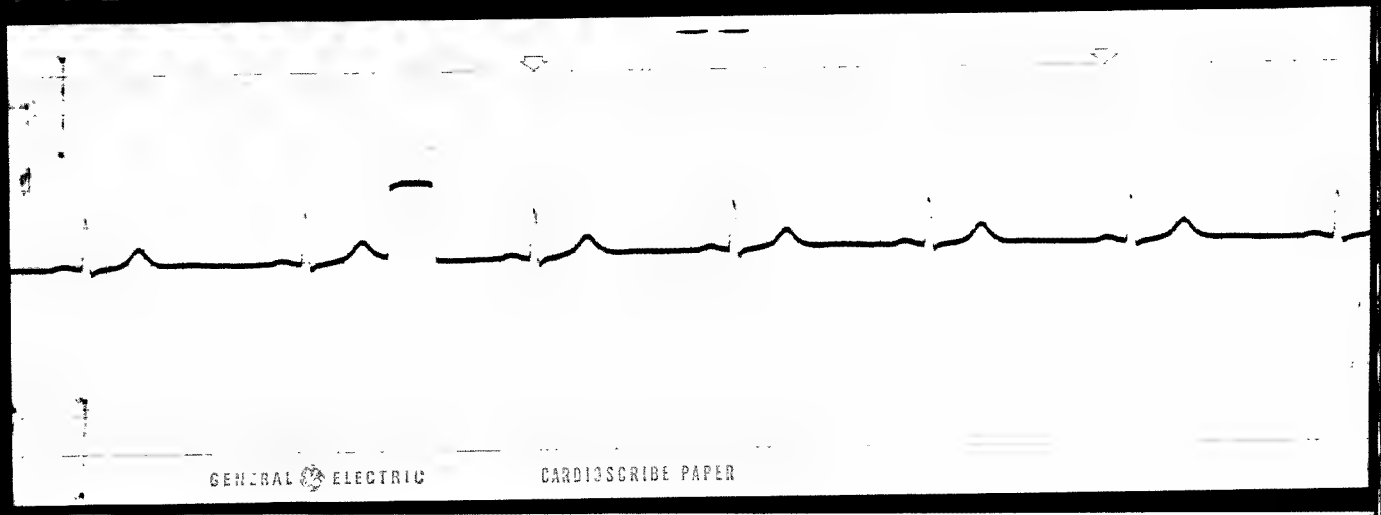
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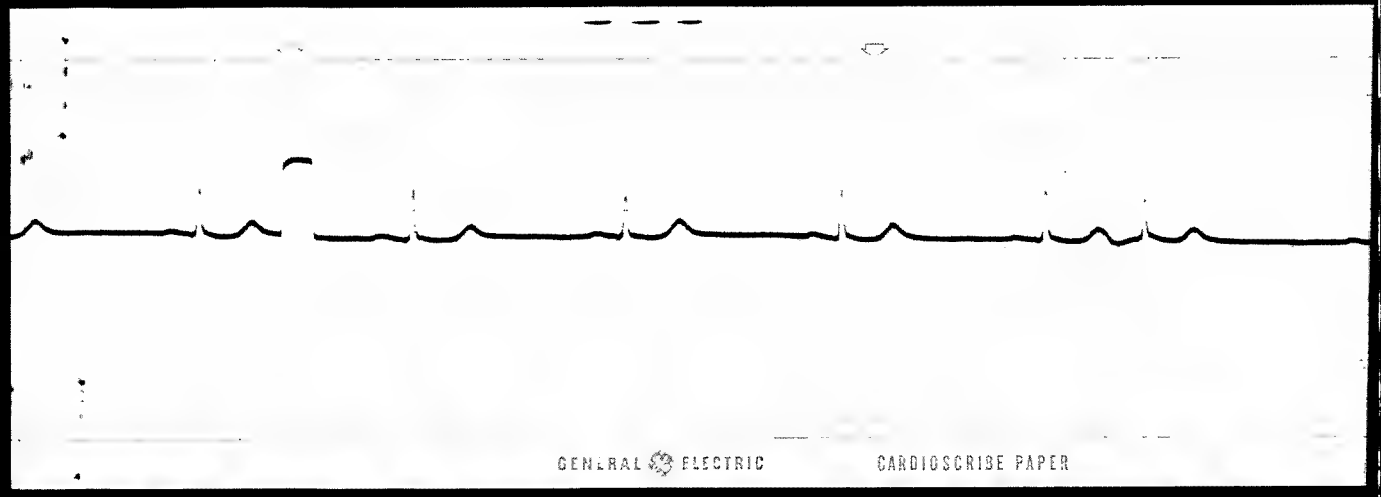
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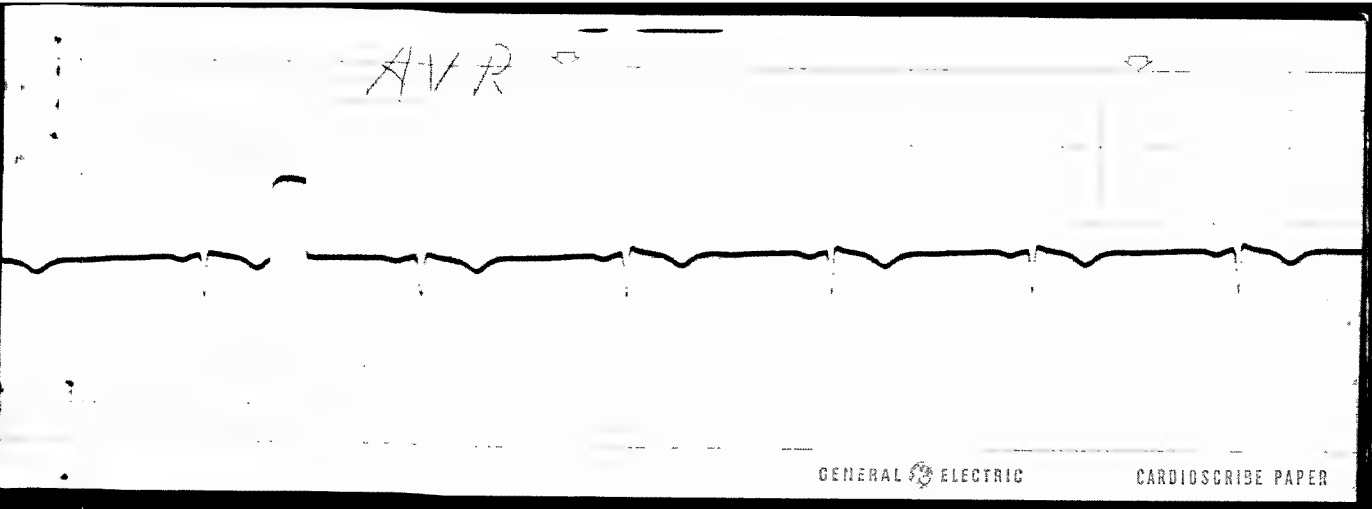
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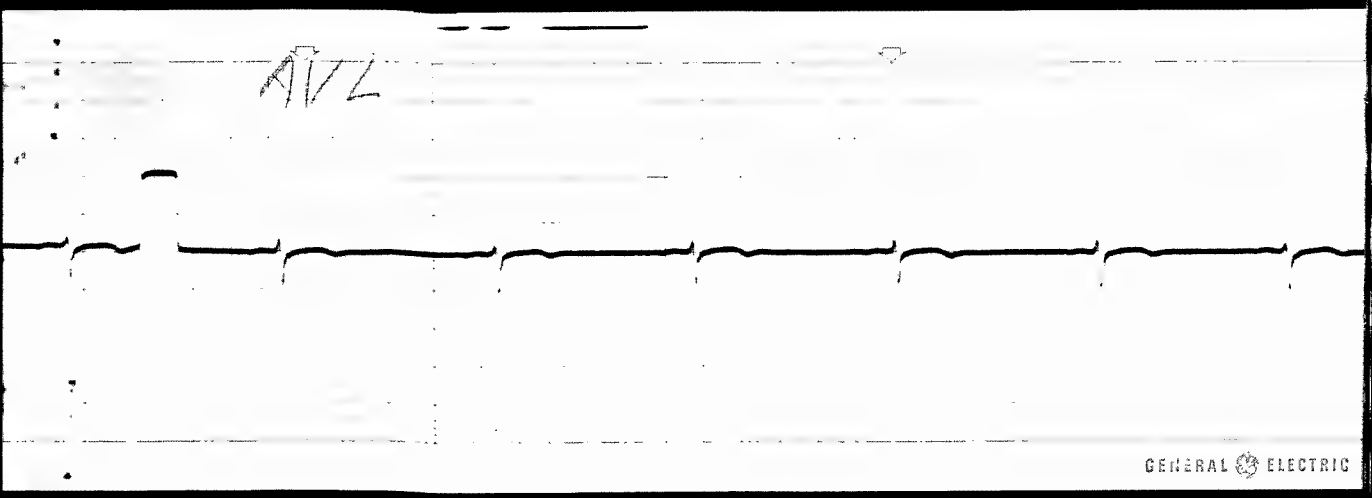
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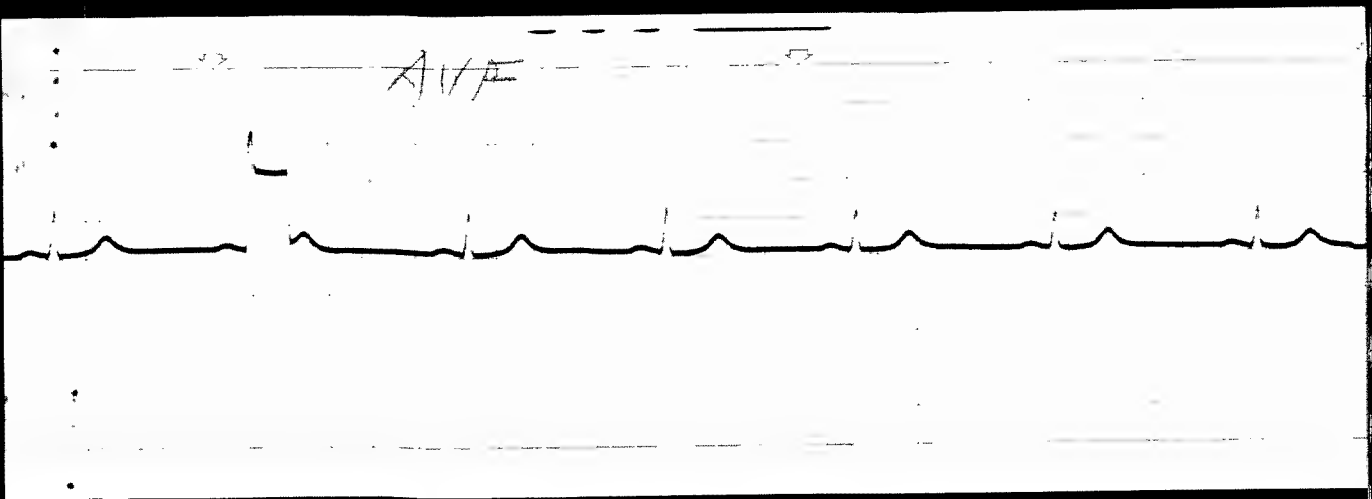
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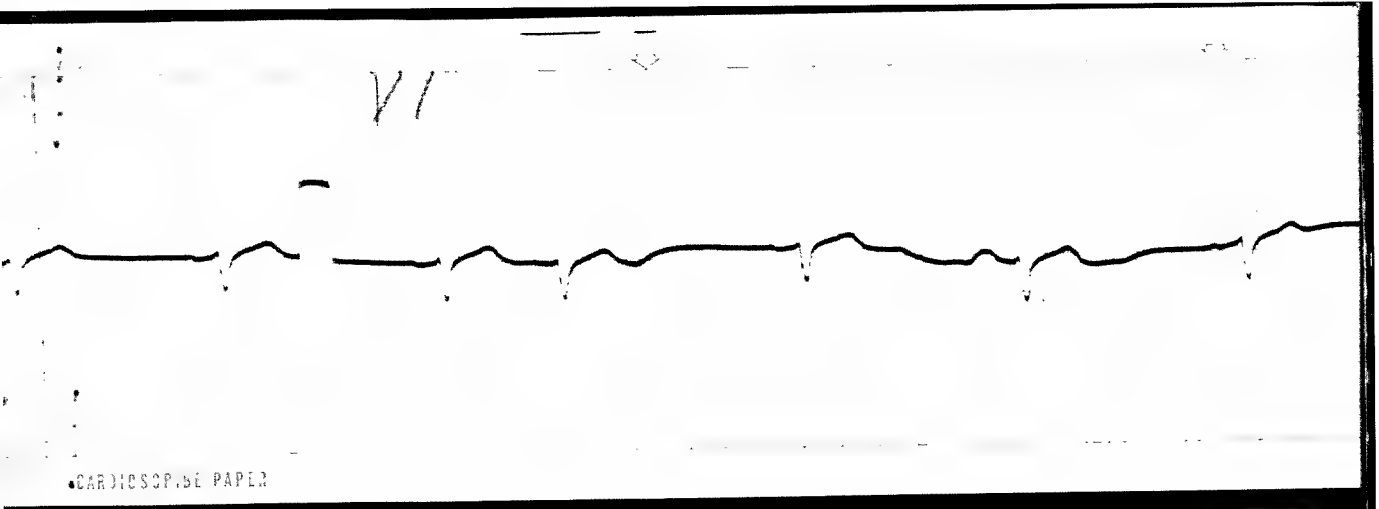
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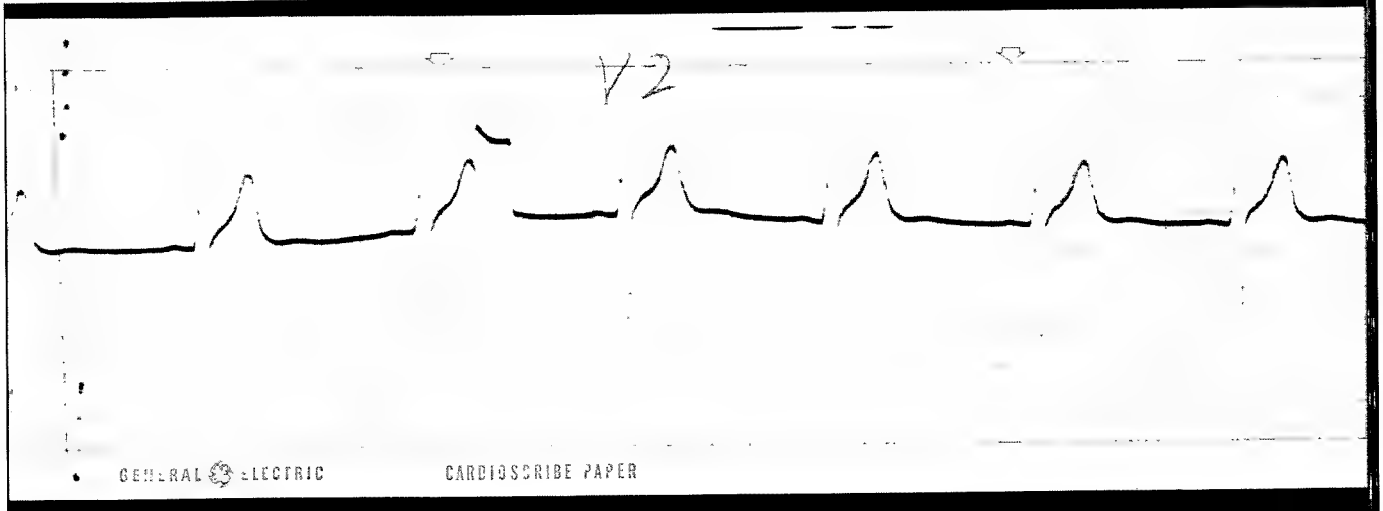
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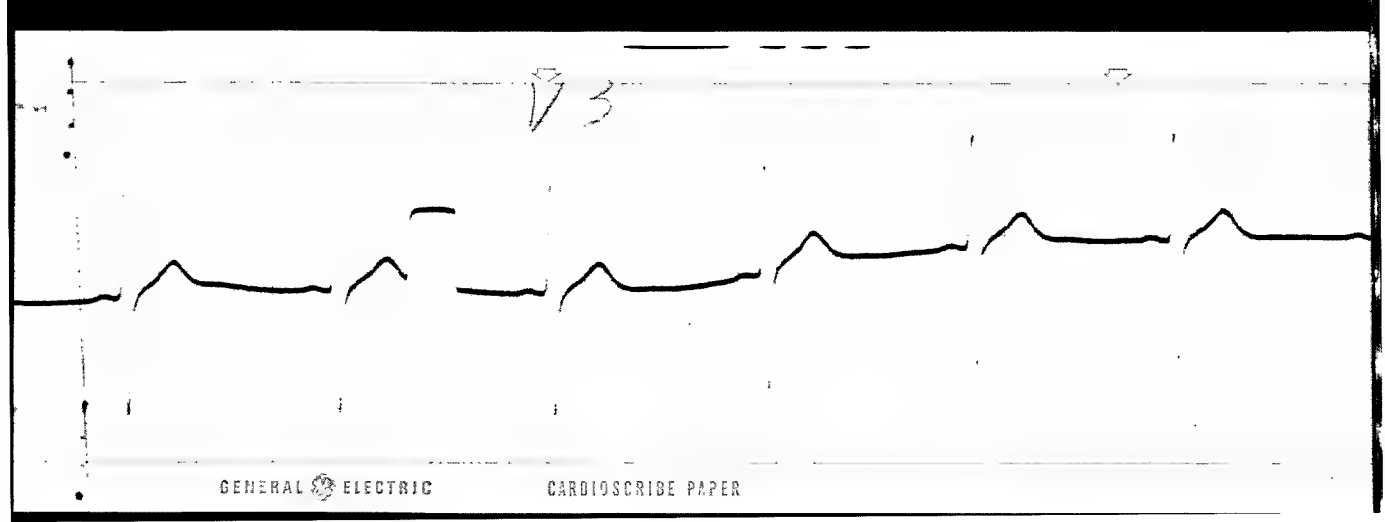
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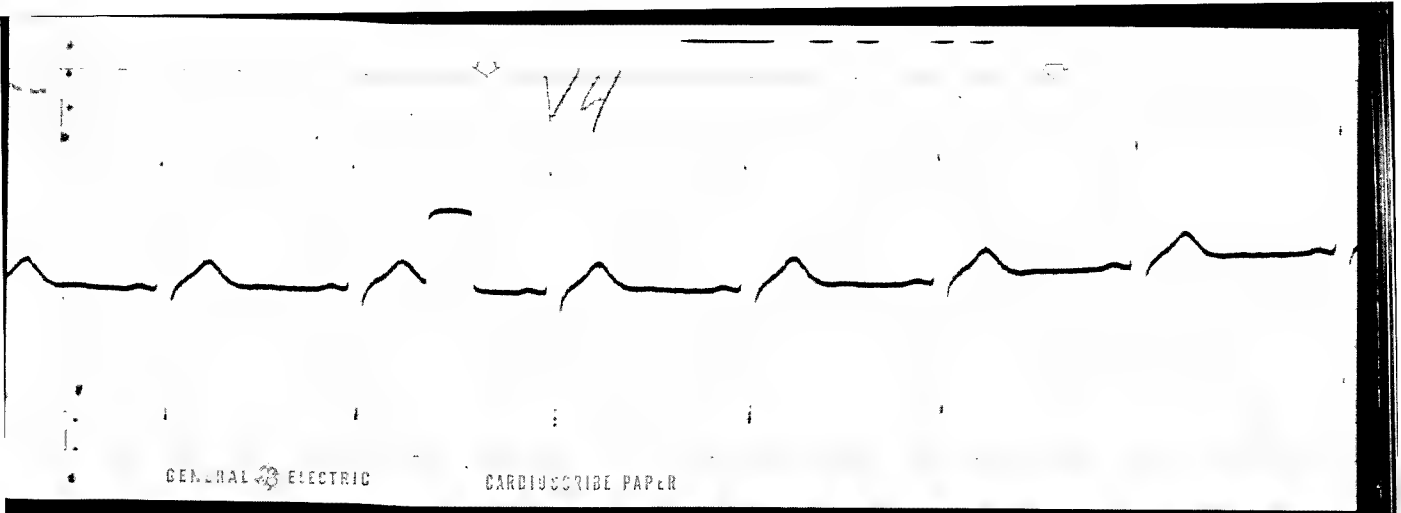
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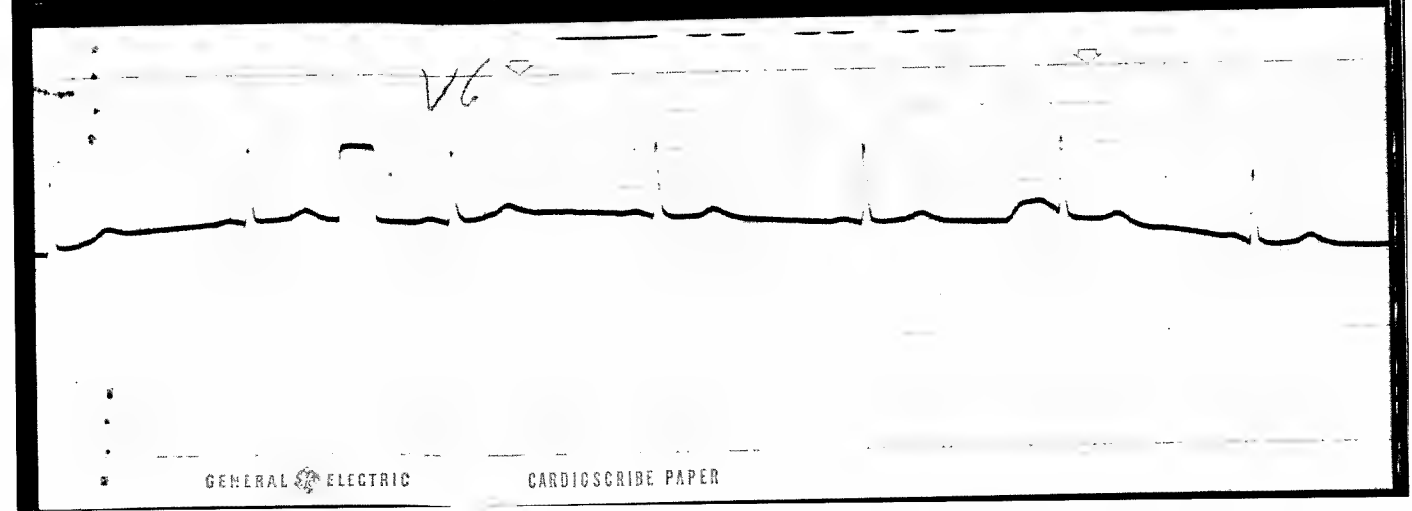
V5
GENERAL ELECTRIC
CARDIOSCRIBE PAPER


V6
GENERAL ELECTRIC
CARDIOSCRIBE PAPER

Standard Form 520
Rev. August 1954
Promulgated
By Bureau of the Budget
Circular A—32

CLINICAL RECORD | ELECTROCARDIOGRAPHIC RECORD

PREVIOUS ECG ☒ YES ☐ NO

CLINICAL IMPRESSION

MEDICATION

☐ EMERGENCY ☐ BEDSIDE
☒ ROUTINE ☒ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B. P.	SIGNATURE OF WARD PHYSICIAN	DATE
41	M	C	69	156		D. J. WILLIAMS LT MC USNR	3-28-62

RHYTHM

AXIS DEVIATION (QRS)

RATES
AURIC. VENT.

INTERVALS
PR QRS QT

P WAVES

QRS COMPLEXES

RS—T SEGMENT

T WAVES

UNIPOLAR EXTREMITY LEADS (*Specify*)

PRECORDIAL LEADS (*Specify*)

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

67-5124 60

(*Continue on reverse*)

NO.	SIGNATURE	TITLE	DATE
ECG		D. J. WILLIAMS LT, MC, USNR	

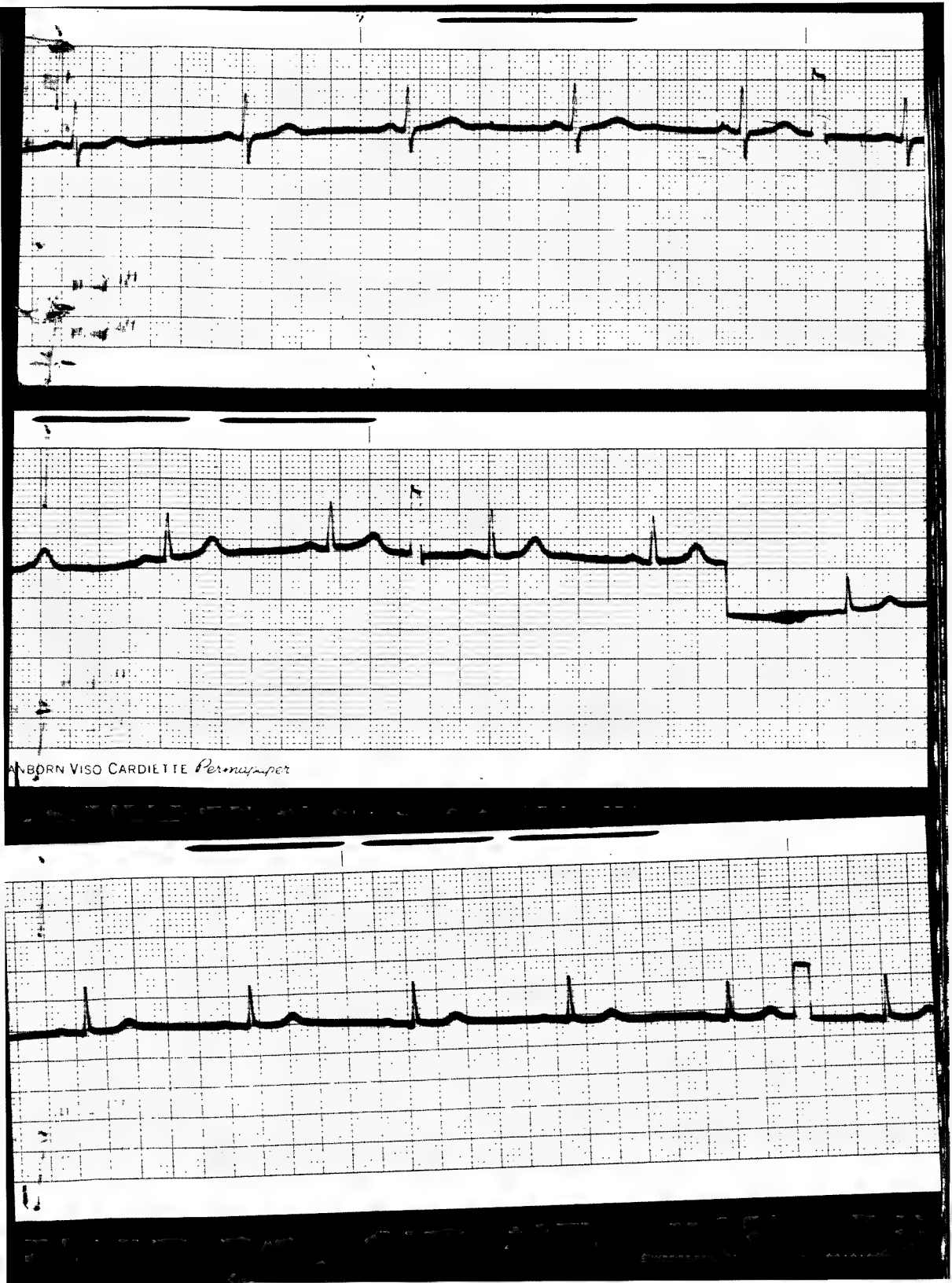
PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

REGISTER NO.

WARD NO.

ANDERSON, Merton Roger, FBI

ELECTROCARDIOGRAPHIC RECORD
Standard Form 520
(*Attach tracings to S. F. 507*)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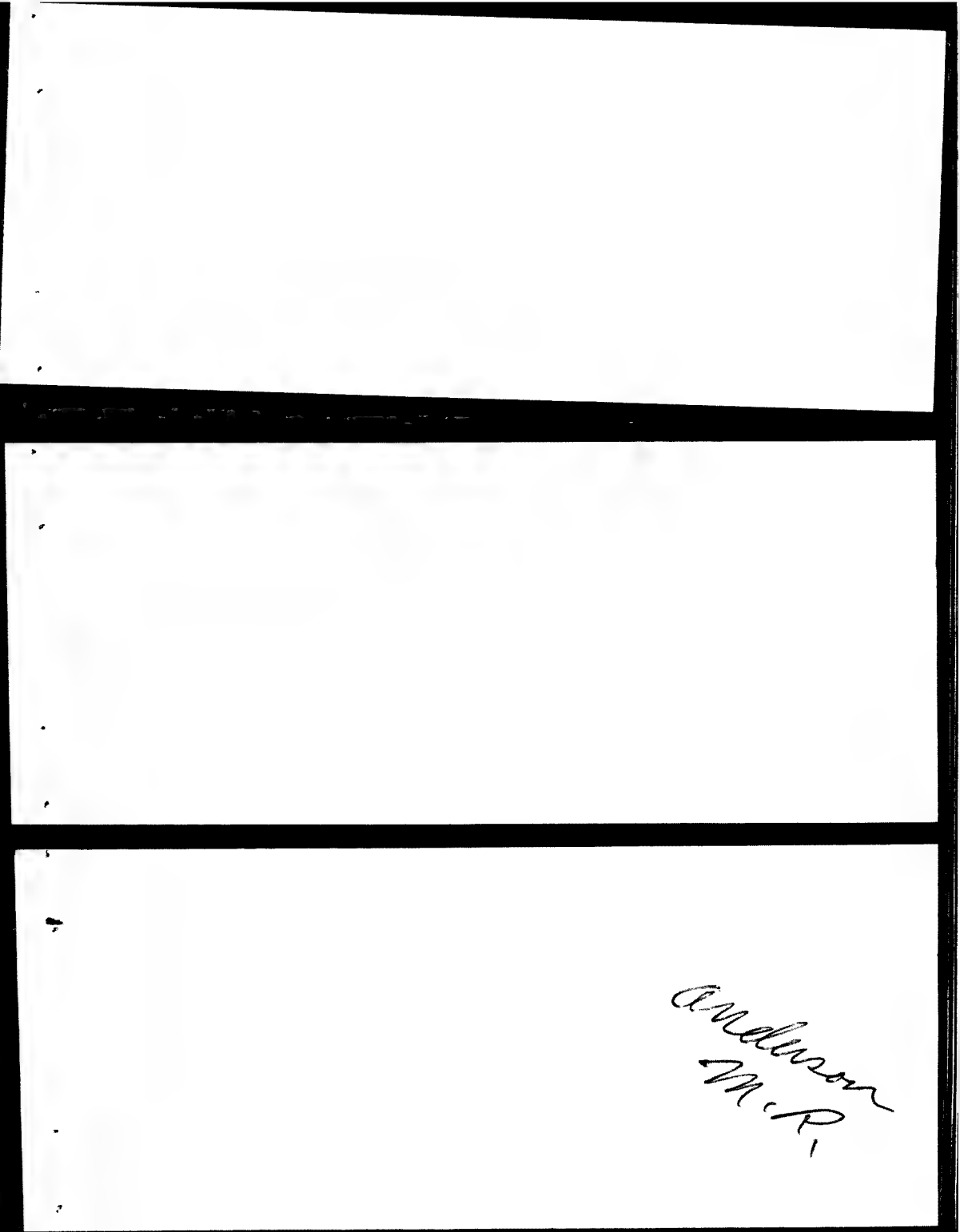
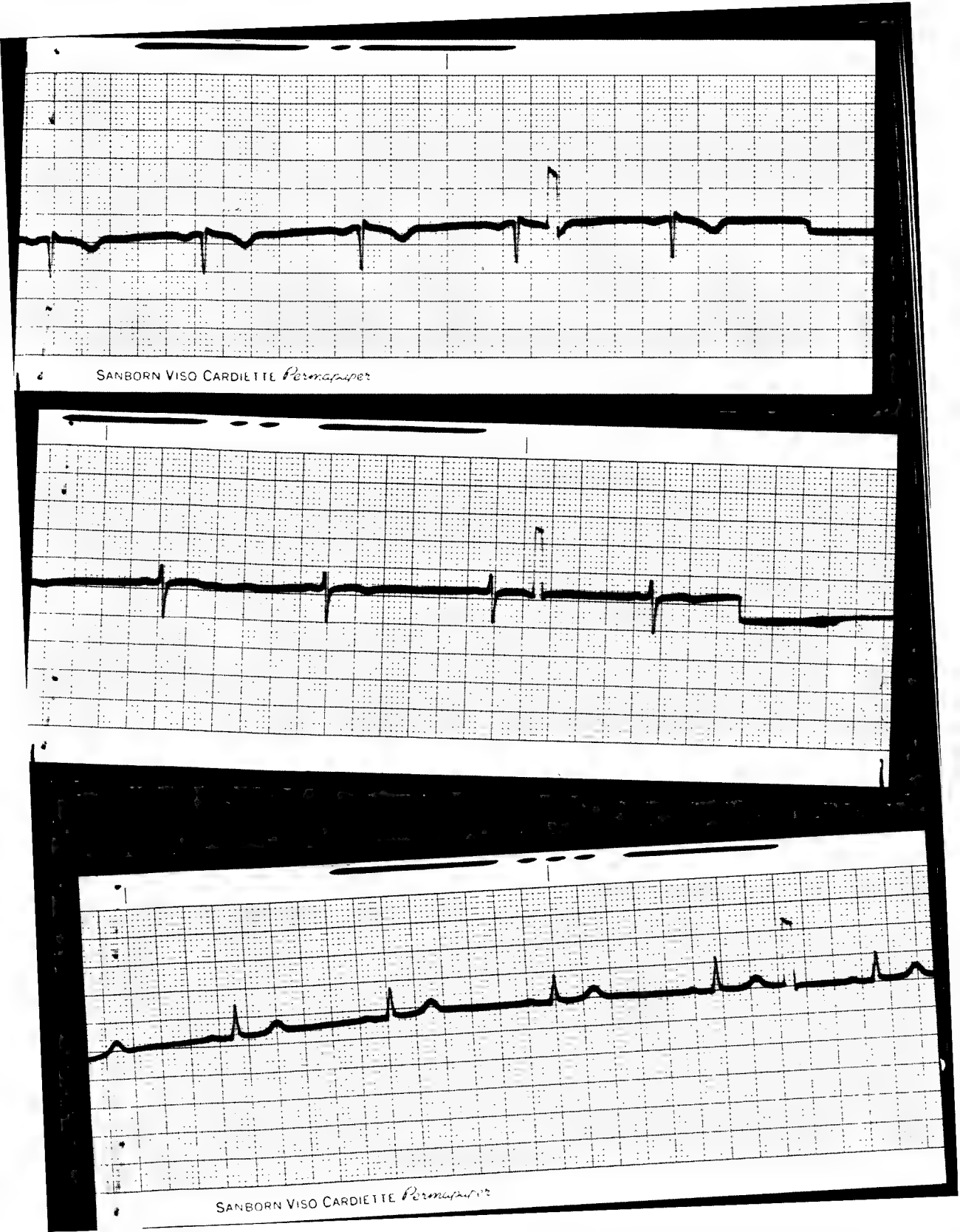

Anderson
M.P.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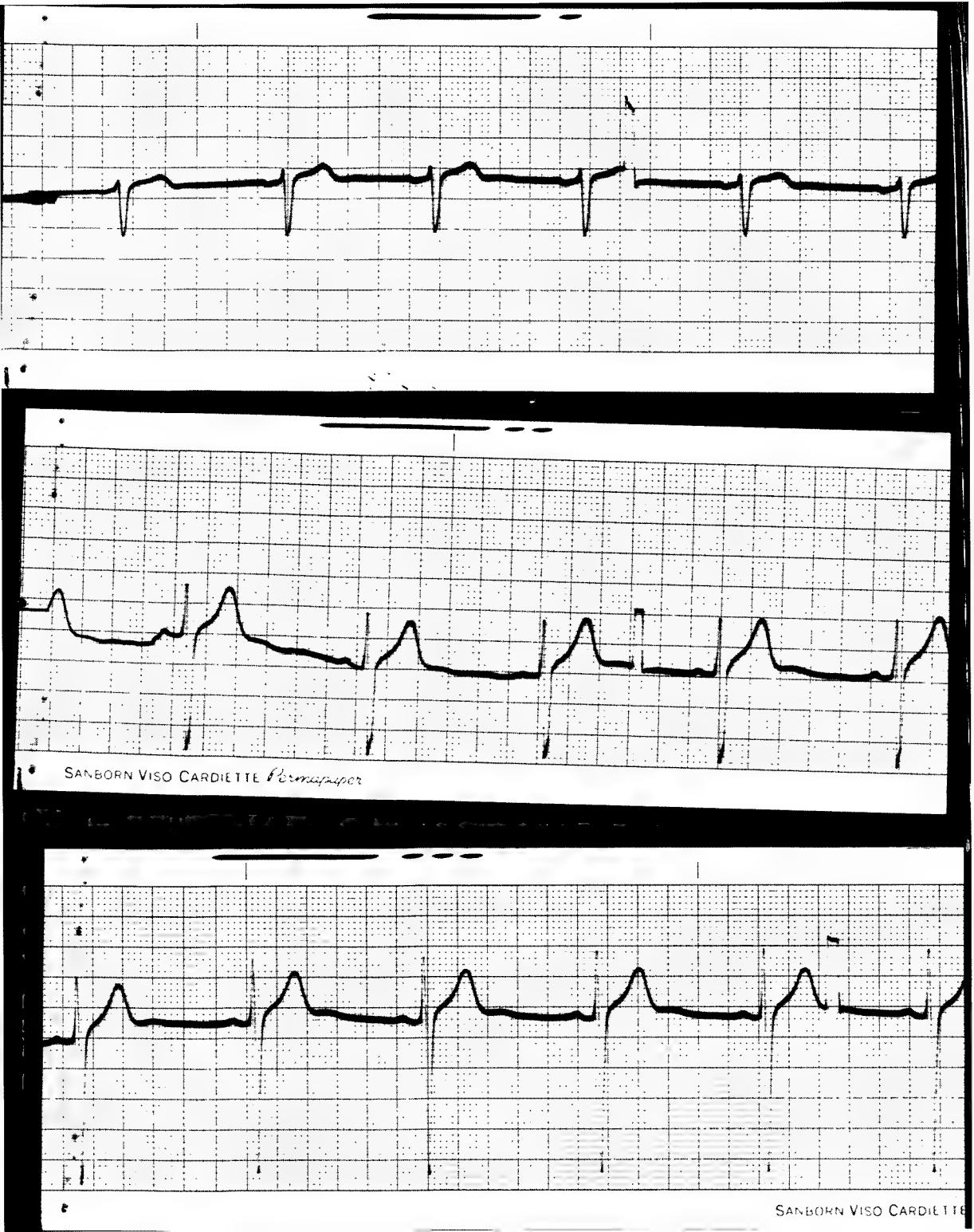
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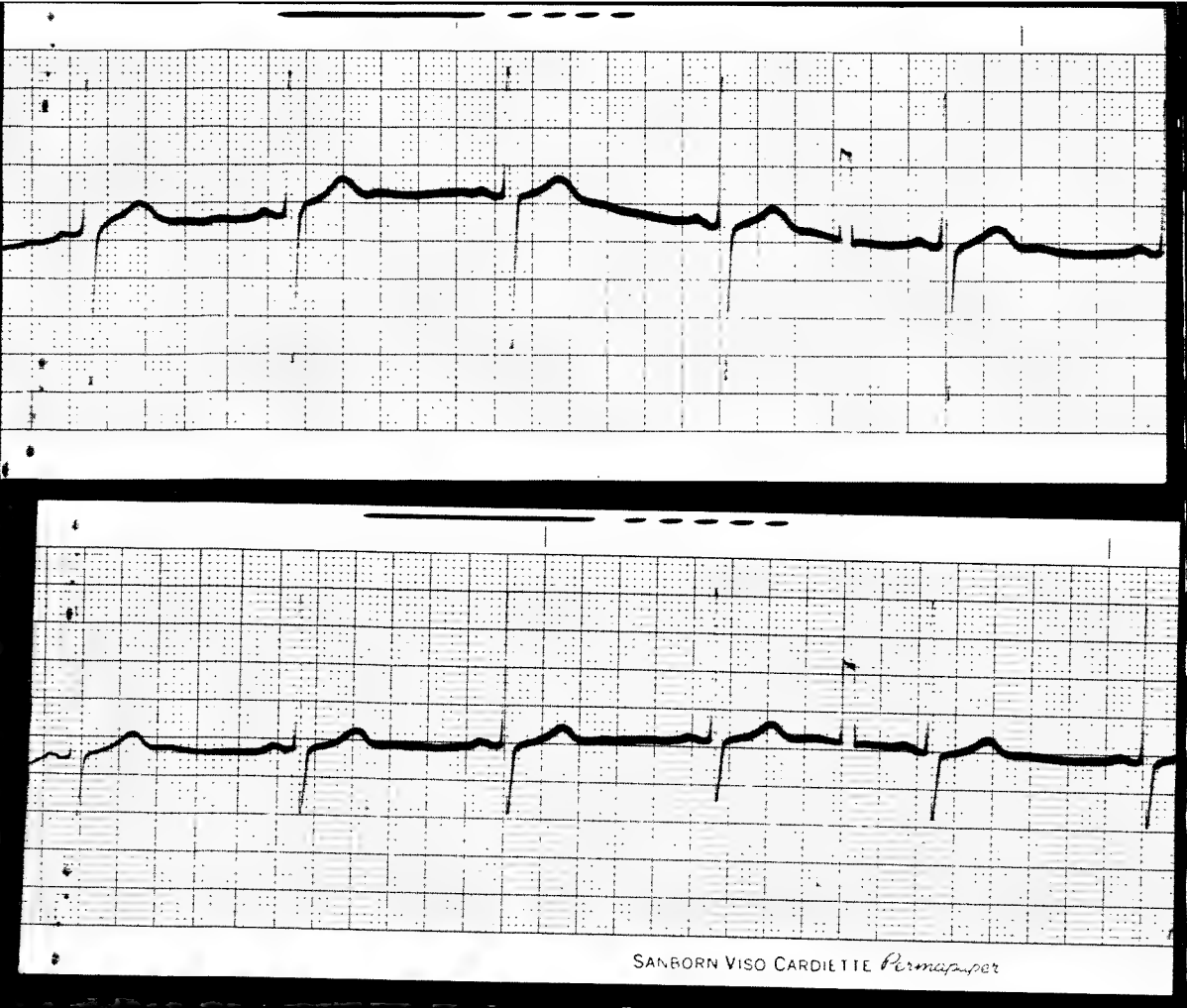
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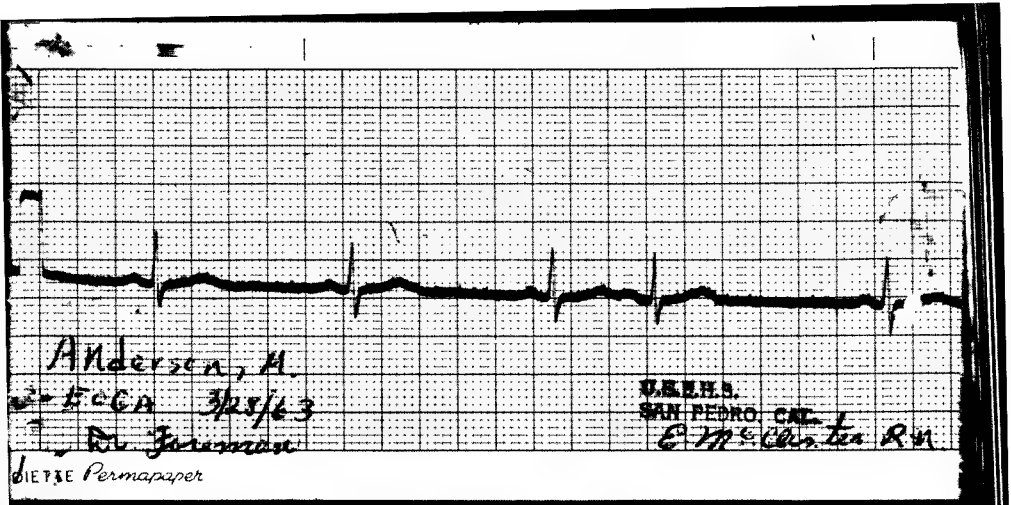
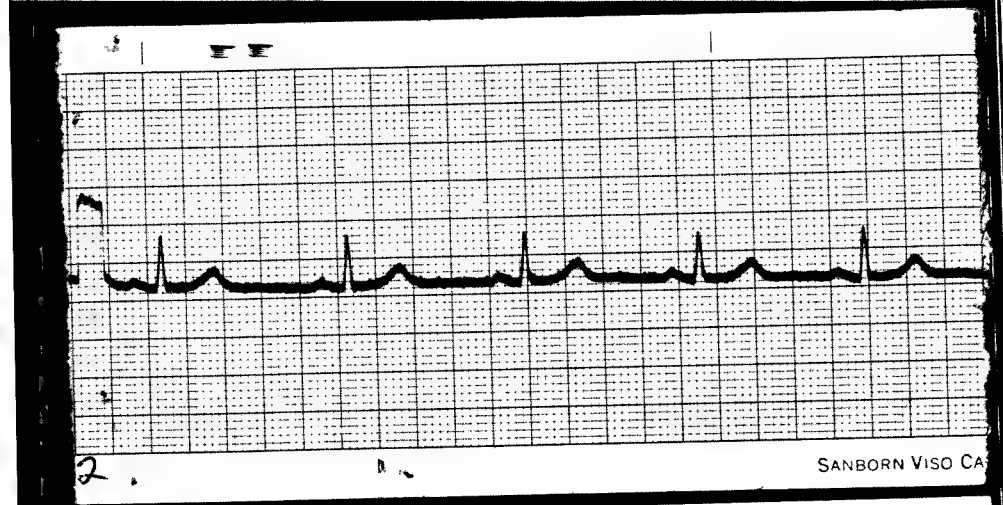
Anderson, Merton · EOGA #7619

ANDERSON, MERTON R. 3/28/63


Anderson, M.
ECG 3/25/63
Dr. Foreman
U.S.P.H.S.
SAN PEDRO, CAL.
E McClinton RN
DIETZGEN Permapaper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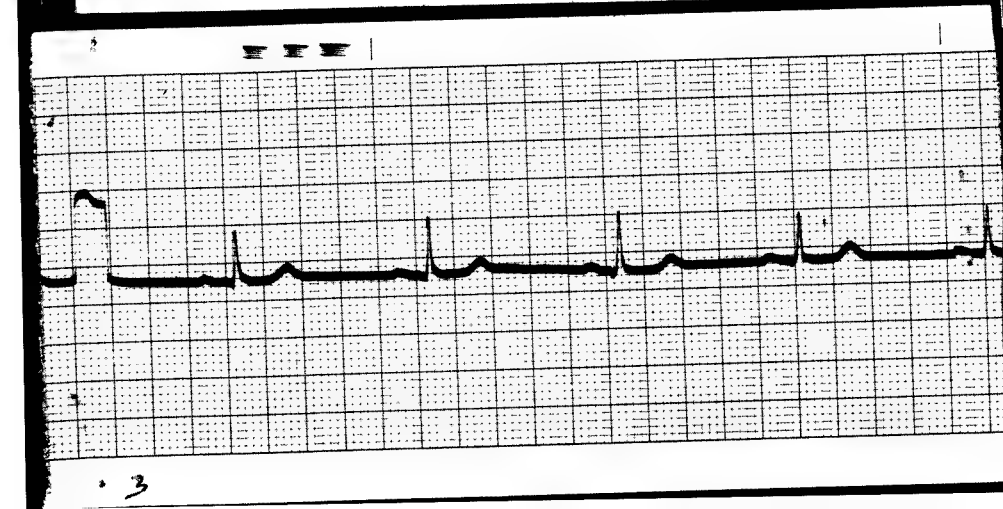
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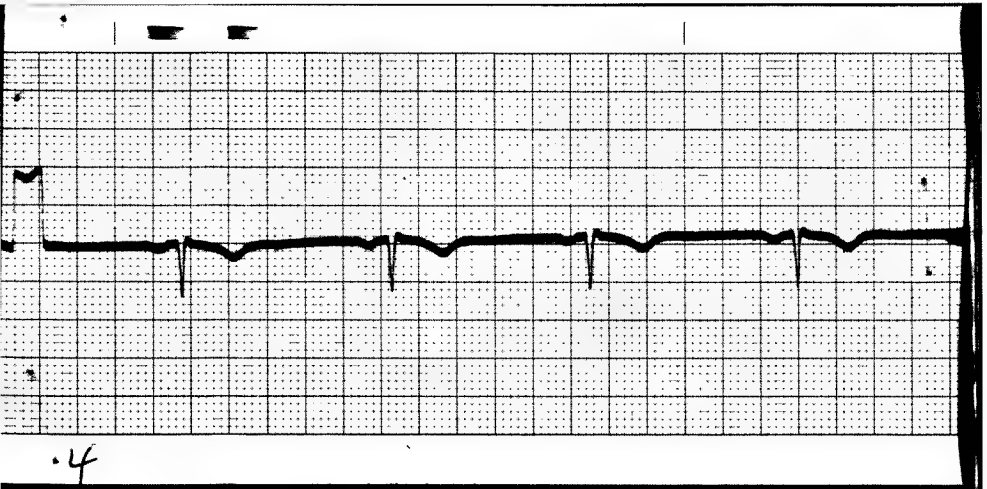

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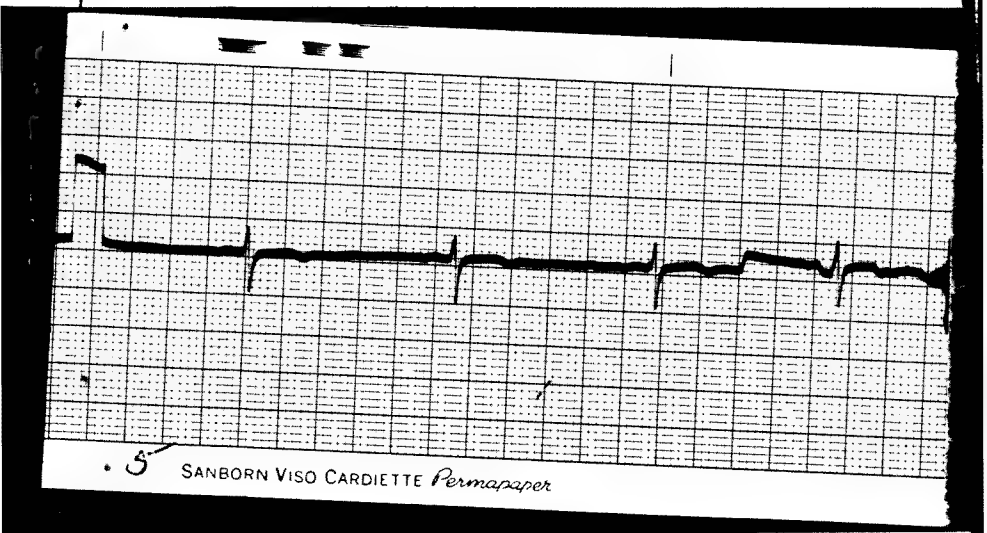

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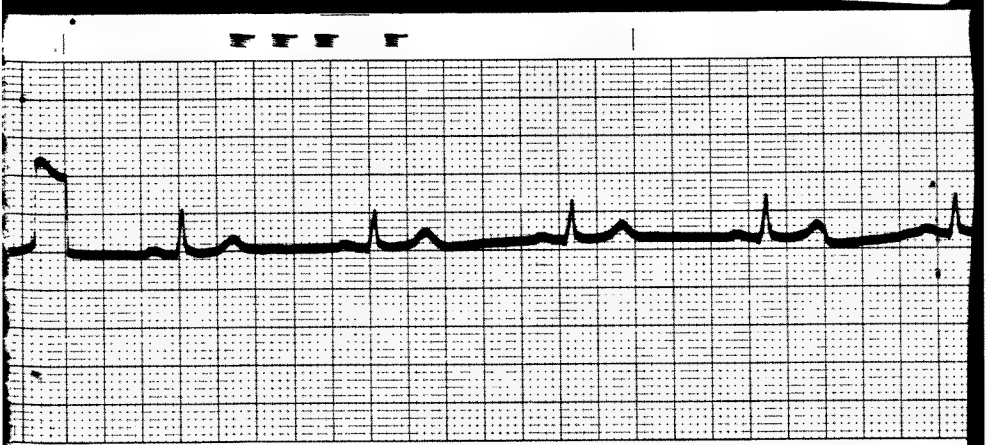

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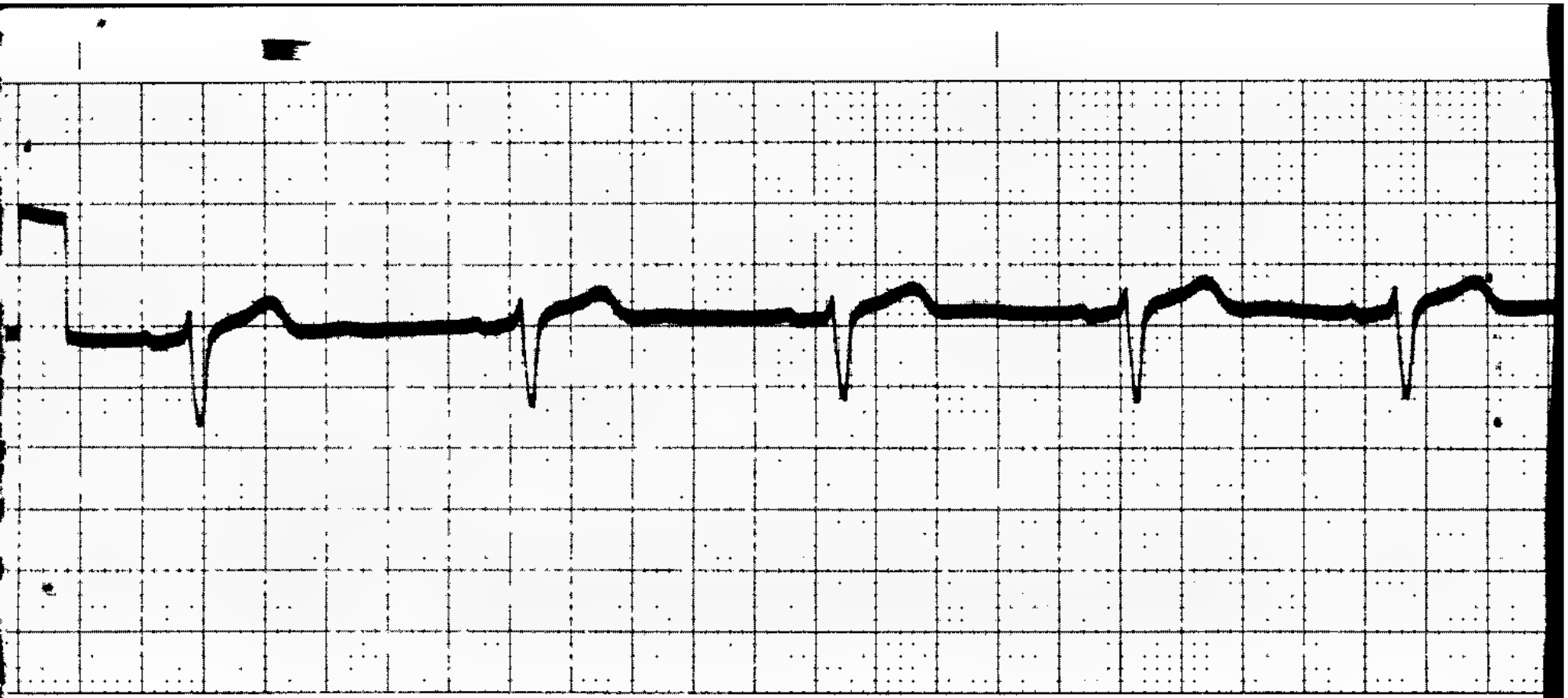
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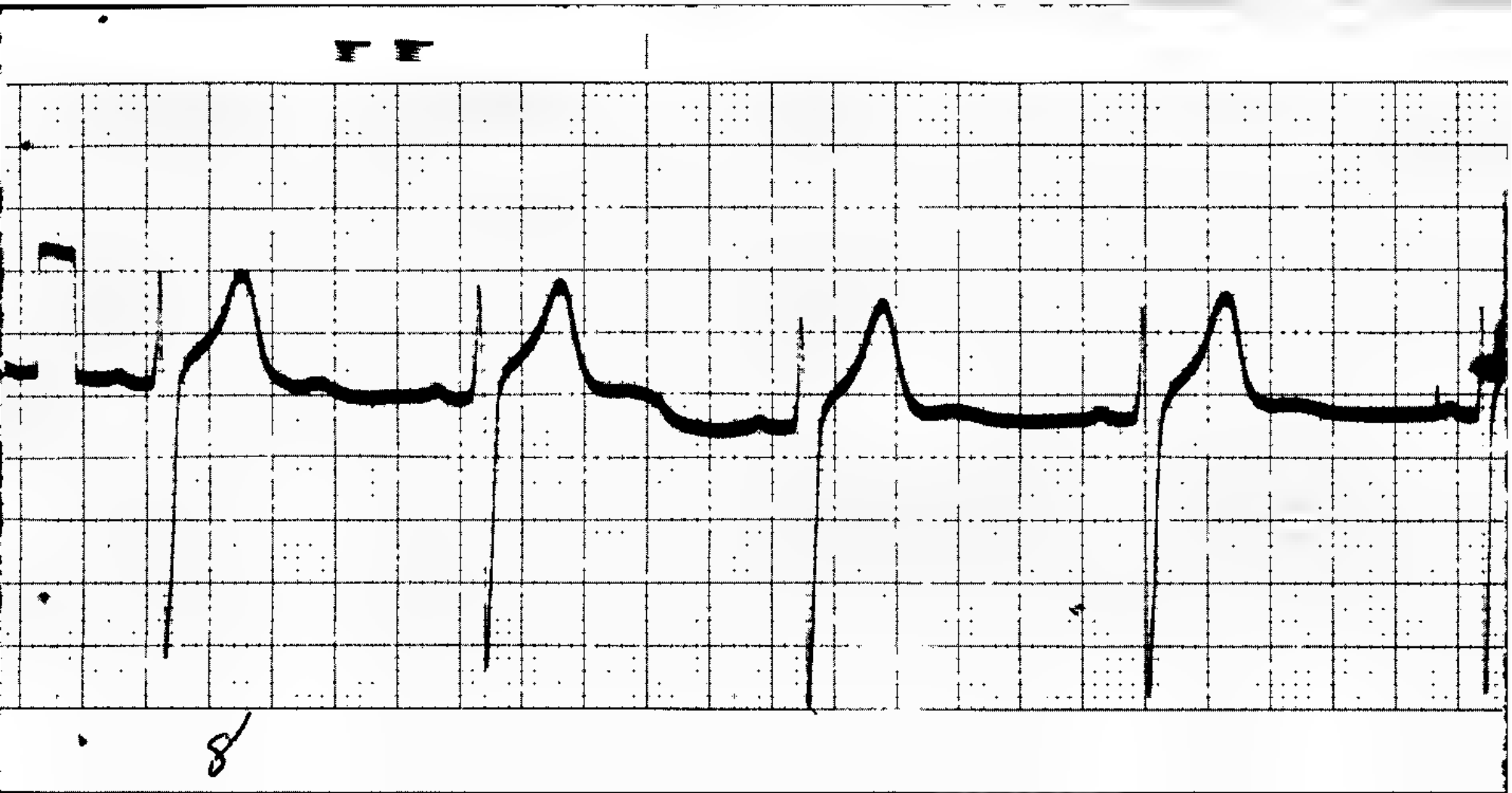

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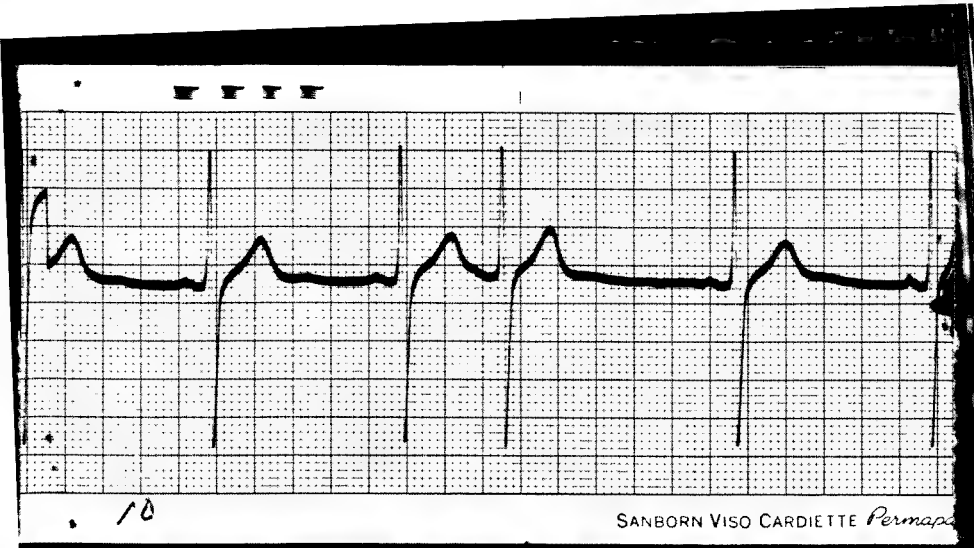
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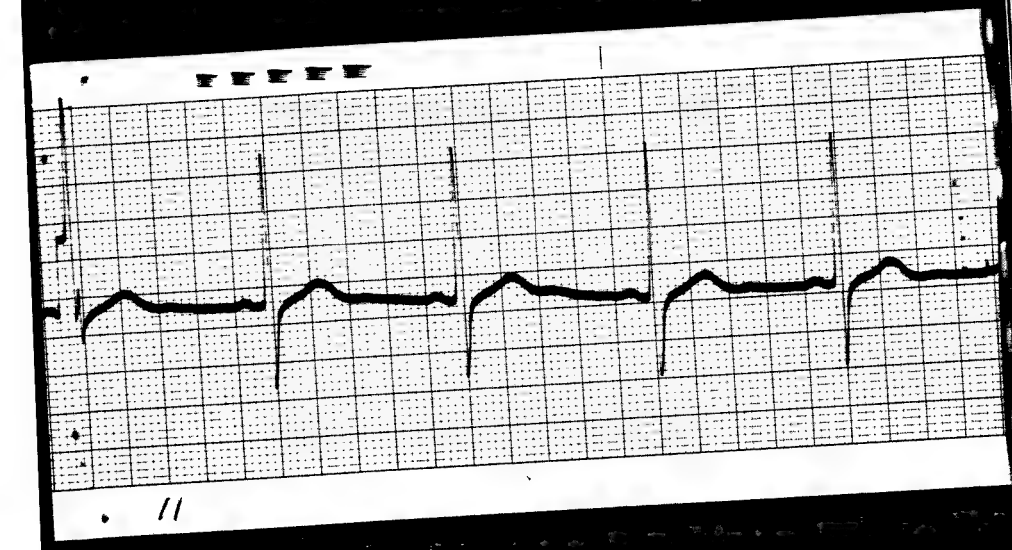
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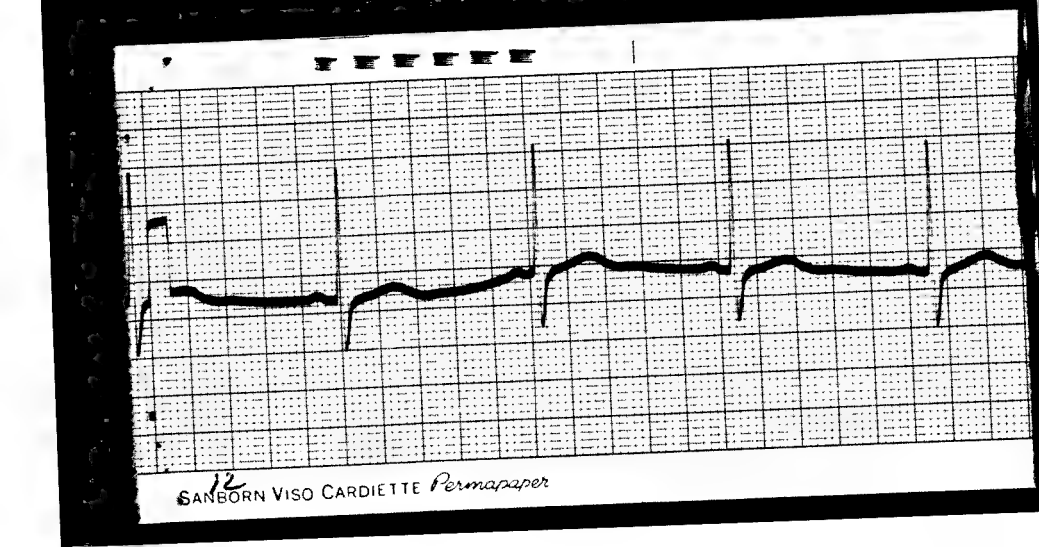
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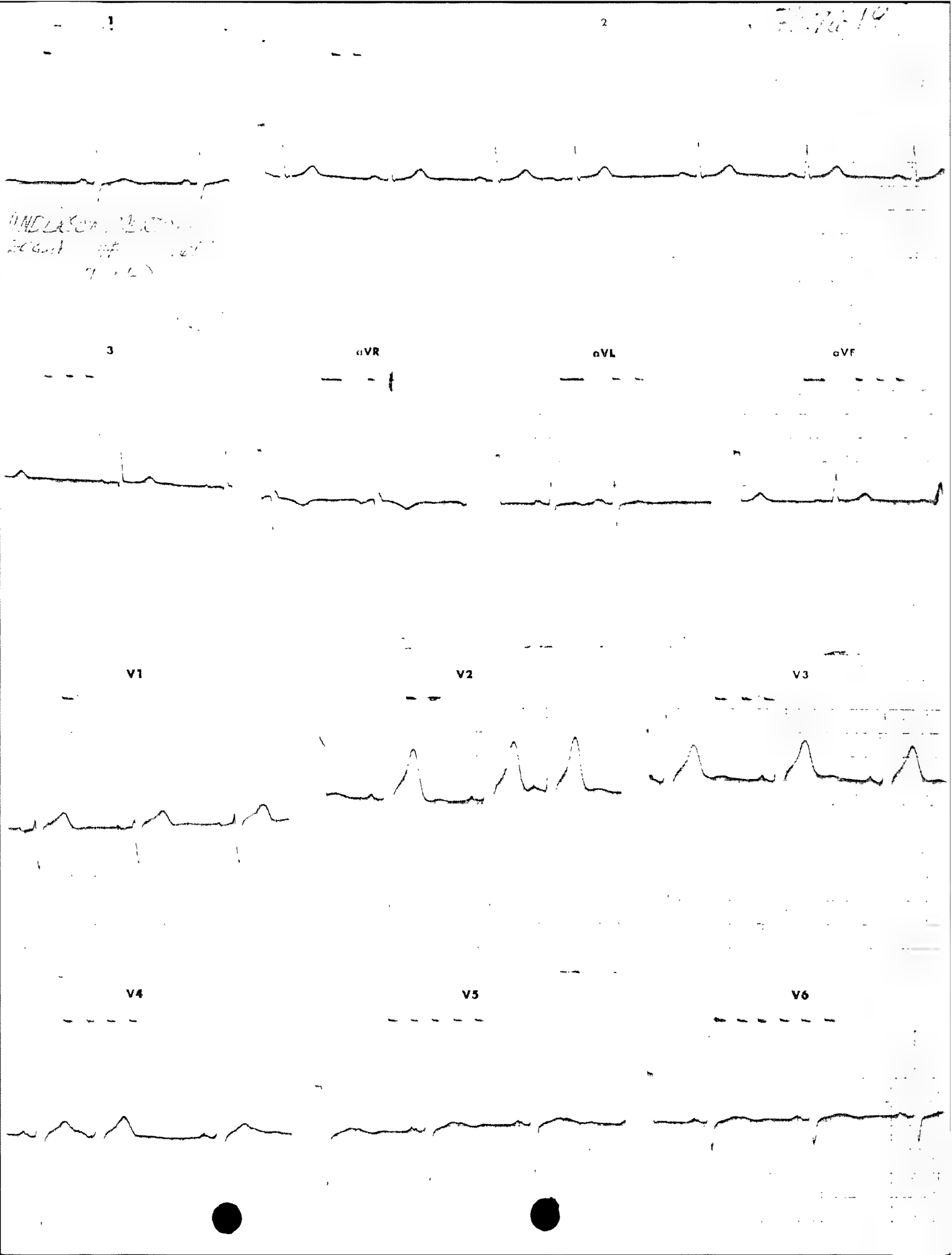
ANDERSON, MERTON


1
2
3
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6

NAME ANDERSON, Mort on R. DATE 4-6-65 CODE #76 19

ADDRESS

TEL. NO. OCCUPATION FBI AGENT

AGE $$ SEX M HT. WT. B.P.

PHYSICIAN Dr. Pischk

HISTORY

DIGITALIS QUINIDINE OTHER PAT. POS.

AURIC. RATE P WAVES Q-T INT.

VENT. RATE P R INT. S-T SEG.

RHYTHM Q-R-S INT. T WAVES

FINDINGS:

REMARKS:

PATIENT

NAME ANDERSON, MERTON R. DATE 4-7-64 AGE 76

ADDRESS

TEL. NO. OCCUPATION SPECIAL AGENT

AGE 45 SEX Male HT. WT B.P.

PHYSICIAN Dr. Watson

HISTORY

DIGITALIS SATURATION OTHER PAST HX

AURIC. RATE P WAVES Q-T INT.

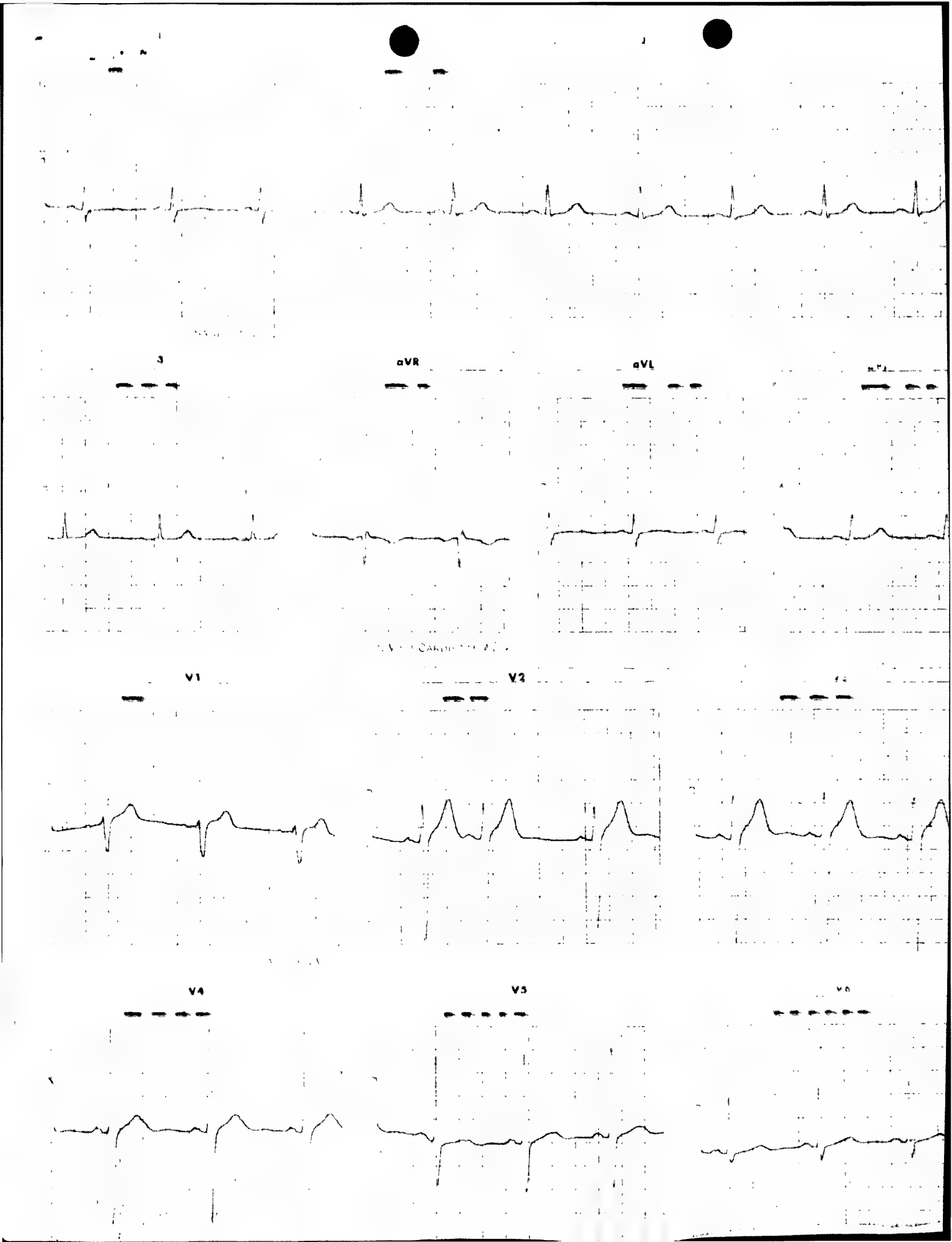
VENT. RATE P-R INT. S-T SEG.

RHYTHM Q R S INT. T WAVES

FINDINGS:

REMARKS:

ORDER BY NO. 651-98
SANBORN CO., WALTHAM 54, MASS.


aVR
aVL
V1
V2
V4
V5

76 19
ANDERSON HERTON R
EOCA
Y RI BO H

NAME _____ DATE _____ CODE 76 19 EOCA

ADDRESS _____

TEL. NO. 4 13 87 OCCUPATION SPECIAL AGENT

AGE _____ SEX _____ HT. _____ WT. _____ B.P. _____

PHYSICIAN Dr. Chauser

HISTORY _____

DIGITALIS _____ QUINIDINE _____ OTHER _____ PAT. POS. _____

AURIC. RATE _____ P WAVES _____ Q-T INT. _____

VENT. RATE _____ P-R INT. _____ S-T SEG. _____

RHYTHM _____ Q-R-S INT. _____ T WAVES _____

FINDINGS: WNL

No change from last exam.

Give APB nn Vk.

PATIENT _____

REMARKS: _____

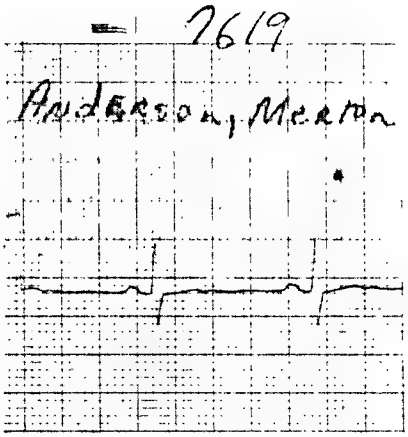
U. S. Public Health Service
314 Federal Building
San Pedro, California

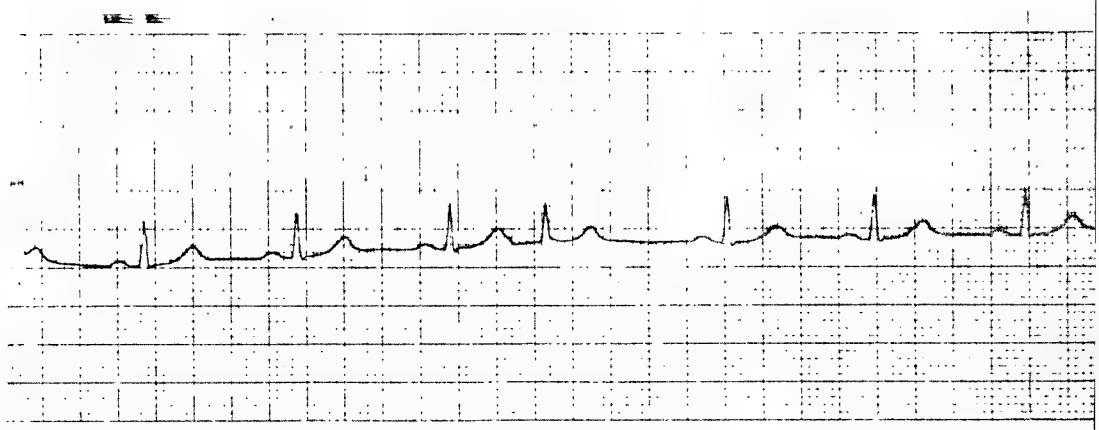
ORDER BY NO. 651-98

1 2

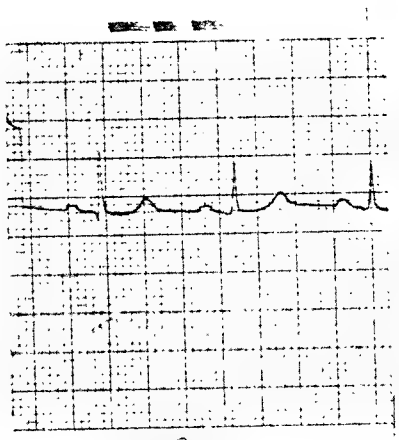
7619

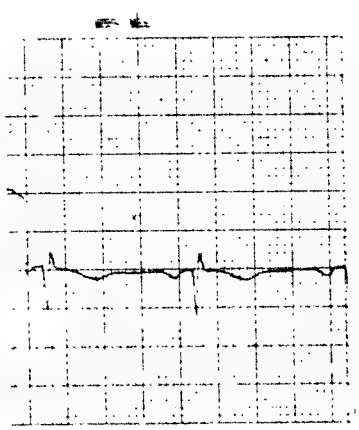
Anderson, Merton

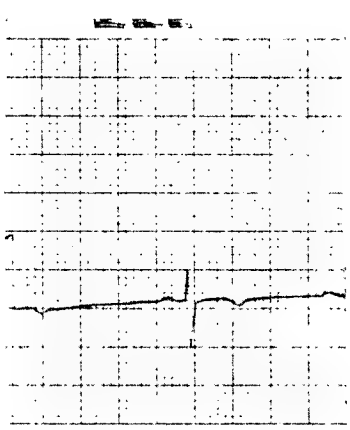


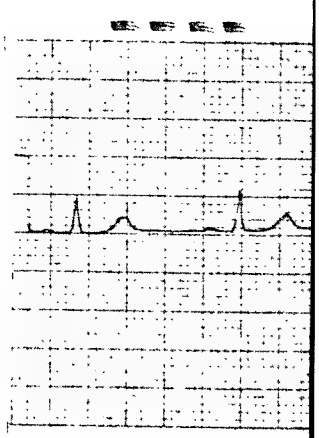


3 aVR aVL aVF



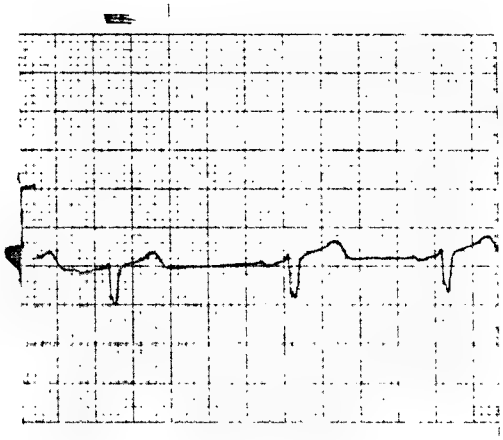


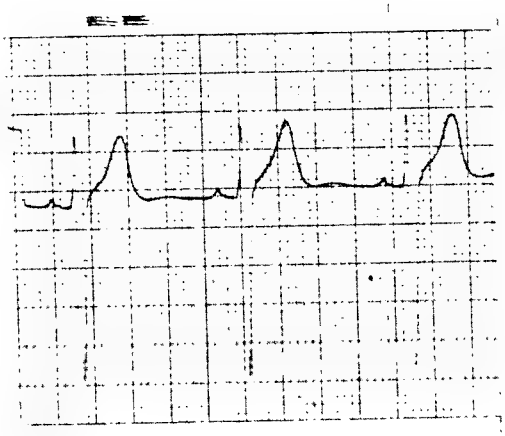


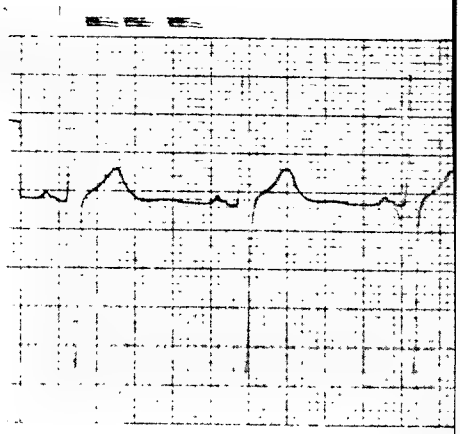


SO CARDIETTE Permapaper

V1 V2 V3

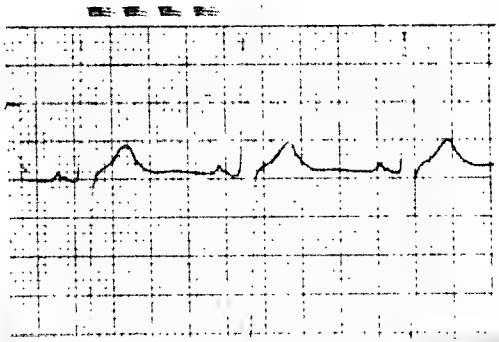


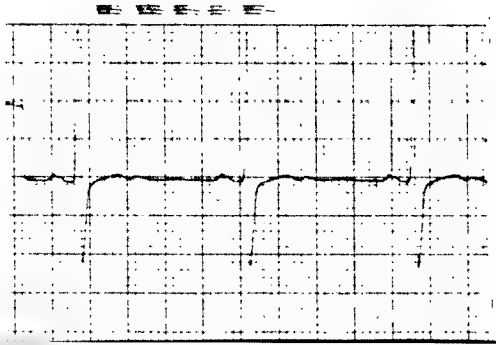


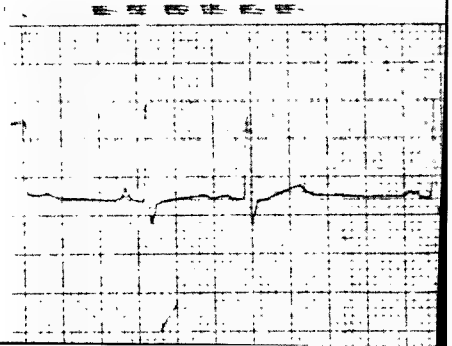


rmapaper

V4 V5 V6







7619

NAME ANDERSON [illegible] DATE April 12, 1968 CODE

ADDRESS

TEL. NO. OCCUPATION FBI

AGE 47 SEX Male HT. WT. B.P.

PHYSICIAN Dr. Olsman

HISTORY

DIGITALIS QUINIDINE OTHER PAT. POS.

AURIC. RATE P WAVES Q-T INT.

VENT. RATE P-R INT. S-T SEG.

RHYTHM Q-R-S INT. T WAVES

FINDINGS:

[illegible] of T waves in (L) precordium [illegible]. PACs.

Imp - non-specific T wave changes.
PACs
No change from [illegible] of 4/67

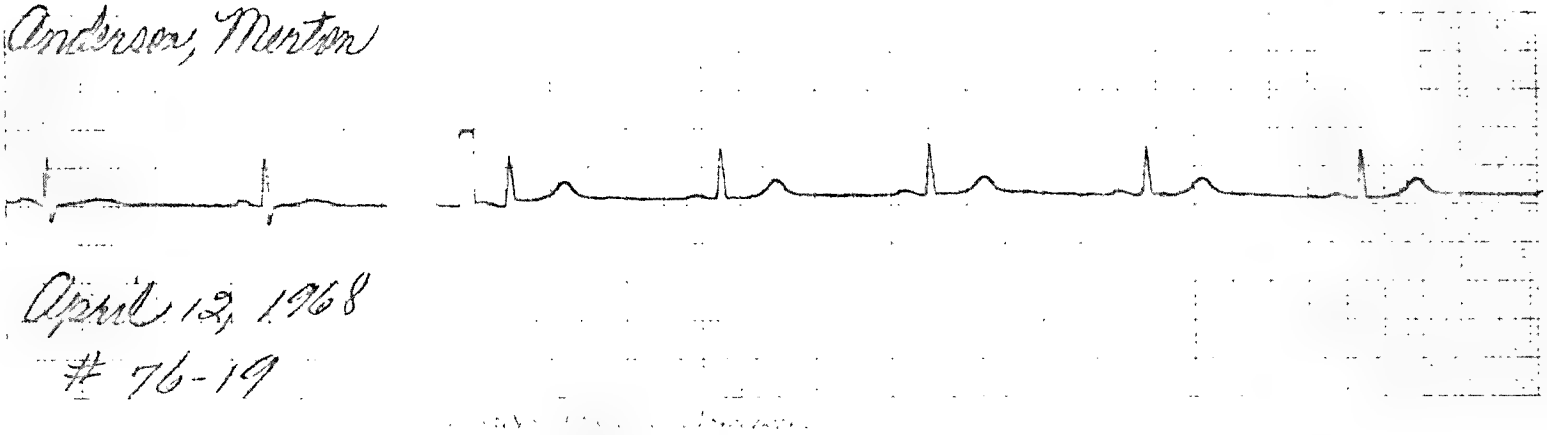
REMARKS:

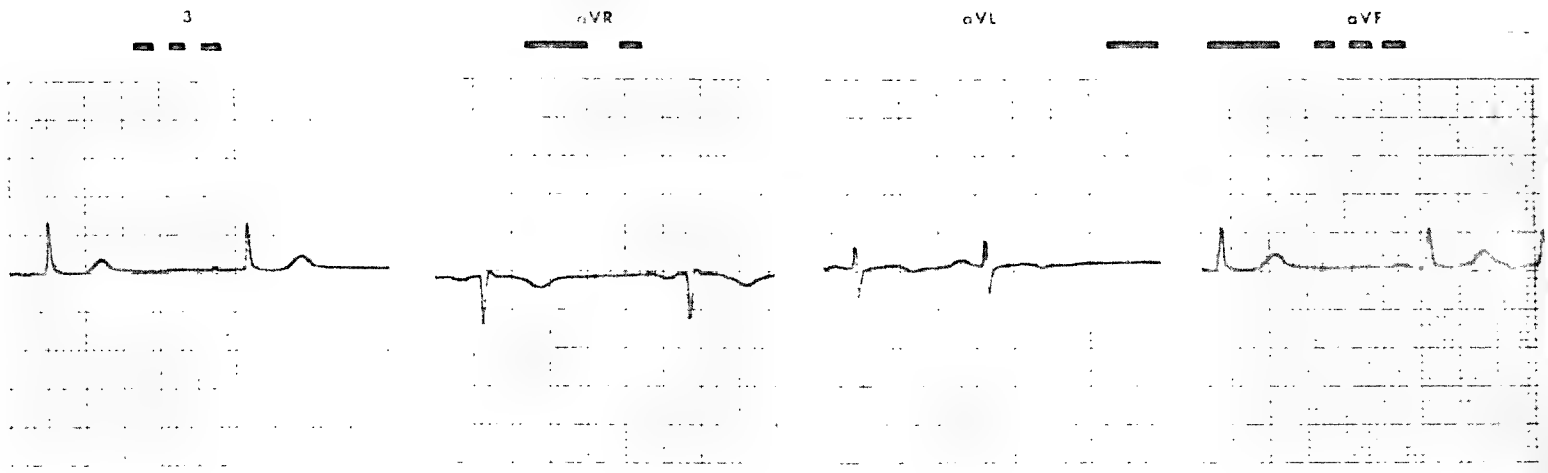
U. S. Public Health Service
[illegible] Building
San Pedro, California 90731

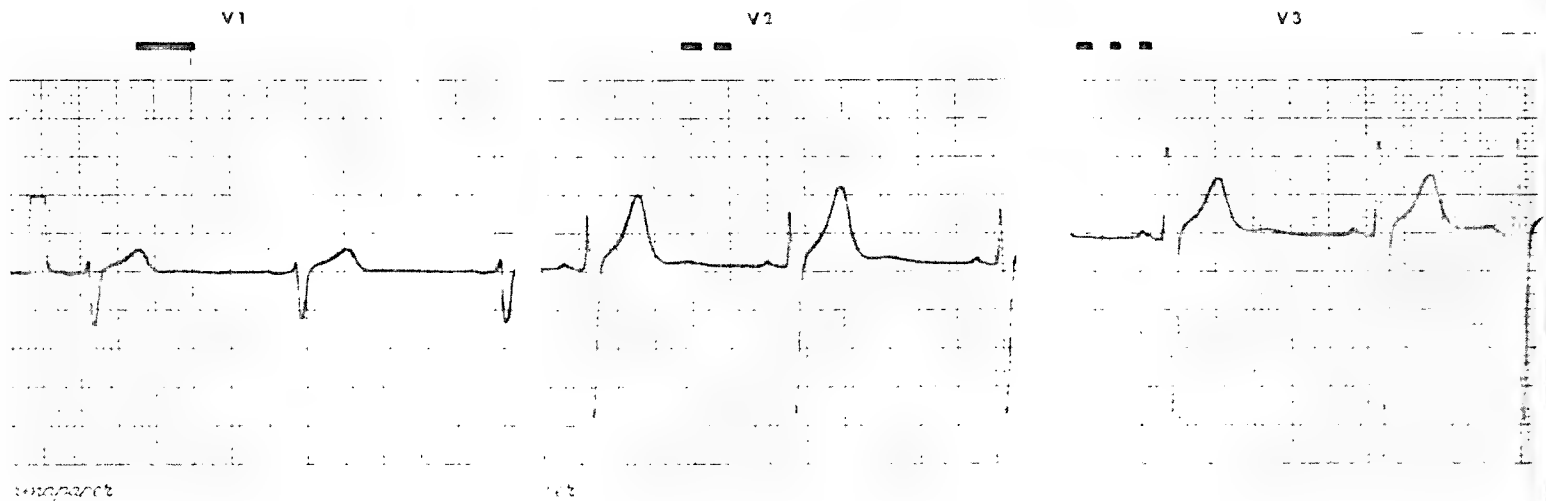
Anderson, Merton

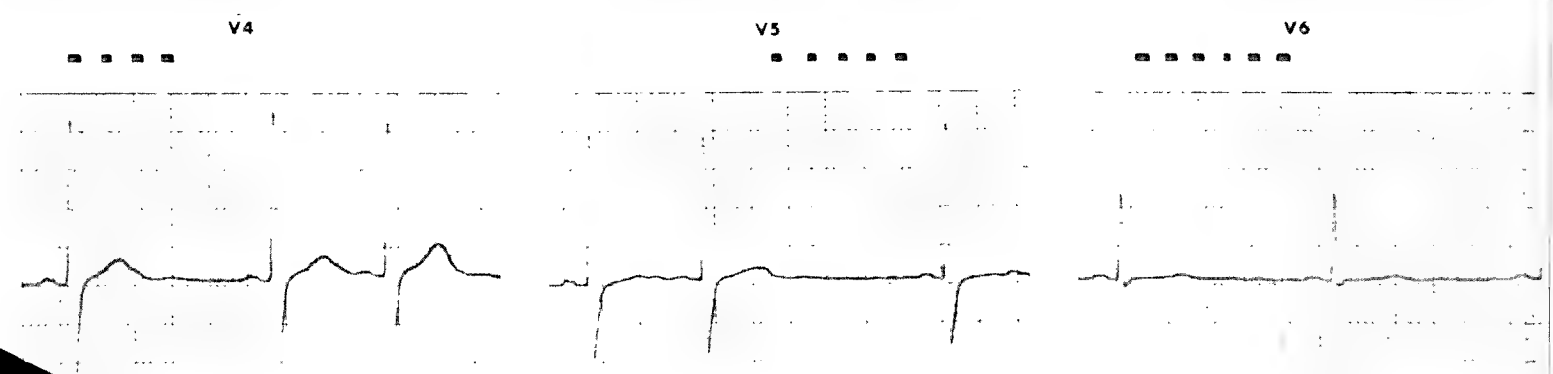
April 12, 1968

76-19









...BIOGRAPHIC RECORD | X YES | NO

CLINICAL IMPRESSION: ANNUAL FBI

MEDICATION: NIACIN

EMERGENCY | BEDSIDE | X ROUTINE | X AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B P	SIGNATURE OF WARD PHYSICIAN	DATE
48	male	cauc	68	160	140/88	JOHN E. GREENE, CAPT, USAF, MC	1 Apr 69

RHYTHM: SINUS

AXIS DEVIATION (QRS): +60

RATES: AURIC. 60 VENT. 60

INTERVALS: PR 0.14 QRS 0.08 QT 0.36

P WAVES: NORMAL

QRS COMPLEXES: NORMAL

RS—T SEGMENT: NORMAL

T WAVES: NORMAL

UNIPOLAR EXTREMITY LEADS (*Specify*)

PRECORDIAL LEADS (*Specify*)

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

FREQUENT PAC'S WITHIN NORMAL LIMITS.

(*Continue on reverse*)

NO. ECG 9386C

SIGNATURE

TITLE: LT COLONEL, USAF, MC

DATE: 1 Apr 1969

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name last, first, middle, grade; date; hospital or medical facility*)

ANDERSON, MERTON R SPECIAL AGENT
807 MED GP (SAC) MARCH AFB CALIF

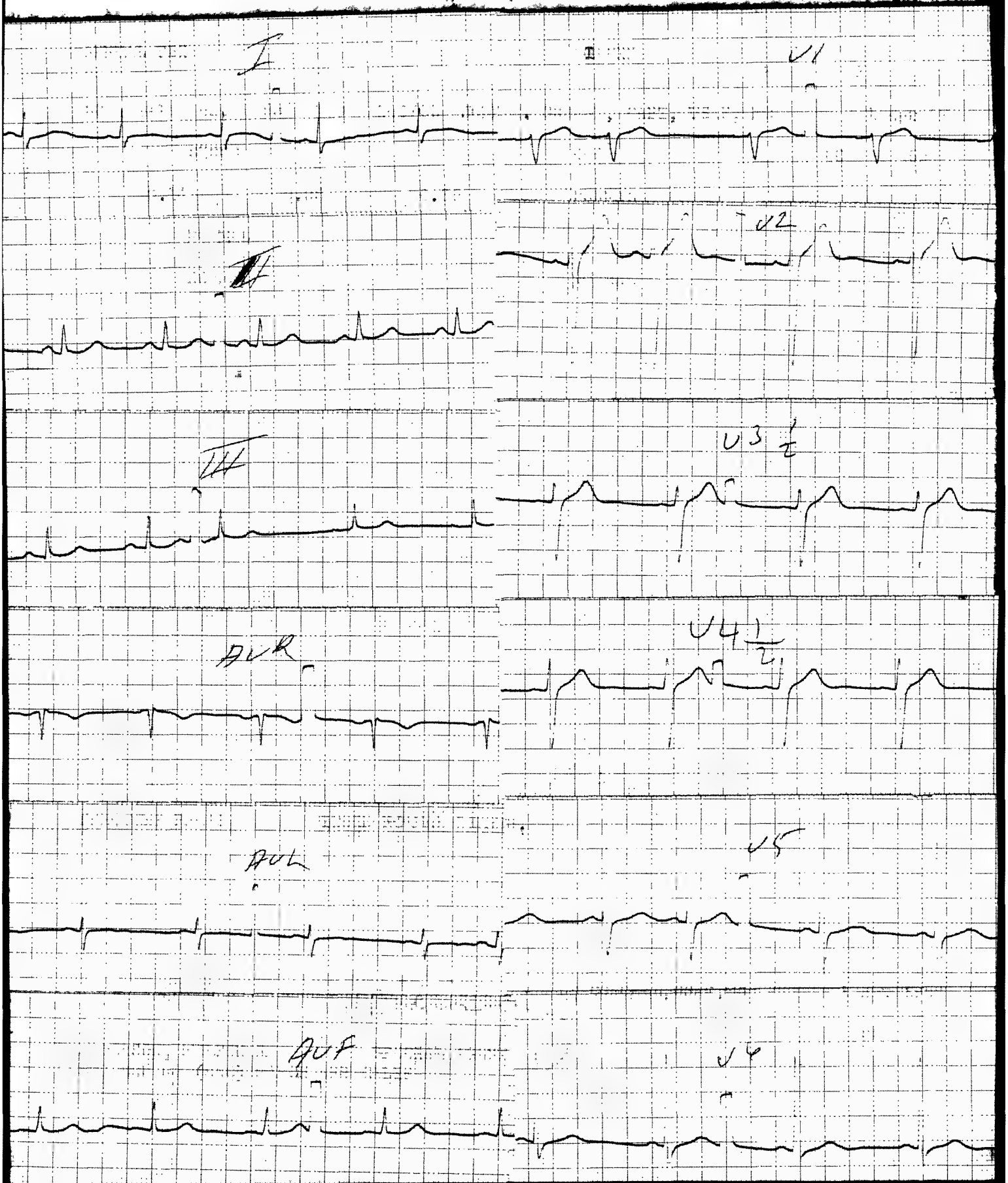
REGISTER NO.

WARD NO.: PE

ELECTROCARDIOGRAPHIC RECORD
Standard Form 520

Attach tracings to S F 507

Standard Form 520
Rev. August 1954
Bureau of the Budget
Circular A-32



Budget Bureau
Approved 50-R0390

REPORT OF MEDICAL HISTORY
U.S. Civil Service Employees and Applicants

This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. TITLE OF POSITION	3. SOCIAL SECURITY NUMBER
ANDERSON, MERTON R.	SPECIAL AGENT	

4. HOME ADDRESS (Number, street or RFD, city or town, State, and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
1234 S. Broadmoor W. Covina, California	ANNUAL PHYSICAL	1 Apr 69

7. SEX	8. TOTAL YEARS GOVERNMENT SERVICE		9. AGENCY	10. ORGANIZATION UNIT
	MILITARY	CIVILIAN		
Male	3½	18	FBI	***

11. DATE OF BIRTH	12. PLACE OF BIRTH	13. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Including ZIP Code)
7/21/20	Wisconsin Dells, Wisc.	807 MED GP (SAC) March AFB, California

14. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

15. DO YOU (Please check at left of each item):

YES	NO	(Check each item)
X		WEAR GLASSES OR CONTACT LENSES
X		HAVE VISION IN BOTH EYES
	X	WEAR A HEARING AID
	X	STUTTER OR STAMMER HABITUALLY
	X	WEAR A BRACE OR BACK SUPPORT

16. HAVE YOU EVER (Please check at left of each item):

YES	NO	(Check each item)
	X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	COUGHED UP BLOOD
	X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

17. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item):

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		SCARLET FEVER, ERYSIPELAS		X		ASTHMA		X		RECENT GAIN OR LOSS OF WEIGHT
	X		DIPHTHERIA		X		SHORTNESS OF BREATH		X		ARTHRITIS OR RHEUMATISM
	X		RHEUMATIC FEVER		X		PAIN OR PRESSURE IN CHEST		X		BONE, JOINT, OR OTHER DEFORMITY
	X		SWOLLEN OR PAINFUL JOINTS		X		CHRONIC COUGH		X		LAMENESS
	X		MUMPS		X		PALPITATION OR POUNDING HEART		X		LOSS OF ARM, LEG, FINGER, OR TOE
	X		COLOR BLINDNESS		X		HIGH OR LOW BLOOD PRESSURE		X		PAINFUL OR "TRICK" SHOULDER OR ELBOW
	X		FREQUENT OR SEVERE HEADACHE		X		CRAMPS IN YOUR LEGS		X		RECURRENT BACK PAIN
	X		DIZZINESS OR FAINTING SPELLS		X		FREQUENT INDIGESTION		X		"TRICK" OR LOCKED KNEE
	X		EYE TROUBLE		X		STOMACH, LIVER, OR INTESTINAL TROUBLE		X		FOOT TROUBLE
X			EAR, NOSE, OR THROAT TROUBLE		X		GALL BLADDER TROUBLE OR GALLSTONES		X		NEURITIS
X			RUNNING EARS		X		JAUNDICE		X		PARALYSIS (Inc. infantile)
X	X		HEARING LOSS		X		ANY ADVERSE REACTION TO SERUM, DRUG, OR MEDICINE		X		EPILEPSY OR FITS
	X		CHRONIC OR FREQUENT COLDS		X		BROKEN BONES		X		CAR, TRAIN, SEA, OR AIR SICKNESS
	X		SEVERE TOOTH OR GUM TROUBLE		X		TUMOR, GROWTH, CYST, OR CANCER		X		FREQUENT TROUBLE SLEEPING
	X		SINUSITIS		X		RUPTURE/HERNIA		X		FREQUENT OR TERRIFYING NIGHTMARES
	X		HAY FEVER		X		APPENDICITIS		X		DEPRESSION OR EXCESSIVE WORRY
	X		HEAD INJURY		X		PILES OR RECTAL DISEASE		X		LOSS OF MEMORY OR AMNESIA
	X		SKIN DISEASES		X		FREQUENT OR PAINFUL URINATION		X		NERVOUS TROUBLE OF ANY SORT
	X		GOITER		X		KIDNEY STONE OR BLOOD IN URINE		X		ANY DRUG OR NARCOTIC HABIT
	X		TUBERCULOSIS		X		SUGAR OR ALBUMIN IN URINE		X		EXCESSIVE DRINKING HABIT
	X		SOAKING SWEATS (Night sweats)		X		BOILS		X		PERIODS OF UNCONSCIOUSNESS

18. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	19. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	20. WHAT IS YOUR USUAL OCCUPATION?	21. ARE YOU (Check one)
One	three years	Special Agent	[X] RIGHT HANDED [ ] LEFT HANDED

OPTIONAL FORM 58
MAY 1968
U.S. CIVIL SERVICE COMMISSION
FPM CHAPTER 293
5058-101

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	22. HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS *(If yes, give reasons)*
	X	23. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	24. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? *(If yes, state reason and give details)*
	X	25. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? *(If yes, describe and give age at which occurred)*
X		26. HAVE YOU EVER BEEN A PATIENT IN ANY TYPE OF HOSPITAL? *(If yes, specify when, where, why, and name of doctor and complete address of hospital)* — Army Air Force Hospital, Hondo, Texas Tonsilectomy, January, 1943. Dr. Unknown
	X	27. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? *(If yes, specify when, where, and give details)*
	X	28. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS FOR OTHER THAN MINOR ILLNESSES? *(If yes, give complete address of doctor, hospital, clinic, and details)*
	X	29. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date and reason for rejection)*
	X	30. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability)*
	X	31. HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? *(If yes, specify what kind, granted by whom, and what amount, when, why)*

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MertonR. Anderson	Merton R. Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

32. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 15 through 31. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

EXAMINEE DENIES ALL SIGNIFICANT INTERVAL HISTORY SINCE LAST PE

TYPED OR PRINTED NAME OF PHYSICIAN	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
CAPT. JOHN E. GREENE FV 3203297 807 Medical Group March AFB, Calif. 92508	1 Apr 69	John E. Greene	

★ U.S. GOVERNMENT PRINTING OFFICE : 1968 O—307-584

NAME 7619 DATE 4-7-70 CODE

ADDRESS ANDERSON, KEATON B
FCI P

TEL. NO. 321 20 N OCCUPATION

AGE 49 SEX HT. WT. B.P.

PHYSICIAN DR. PANITCH 4 7 70

HISTORY

DIGITALIS QUINIDINE OTHER PAT. POS.

AURIC. RATE P WAVES Q-T INT.

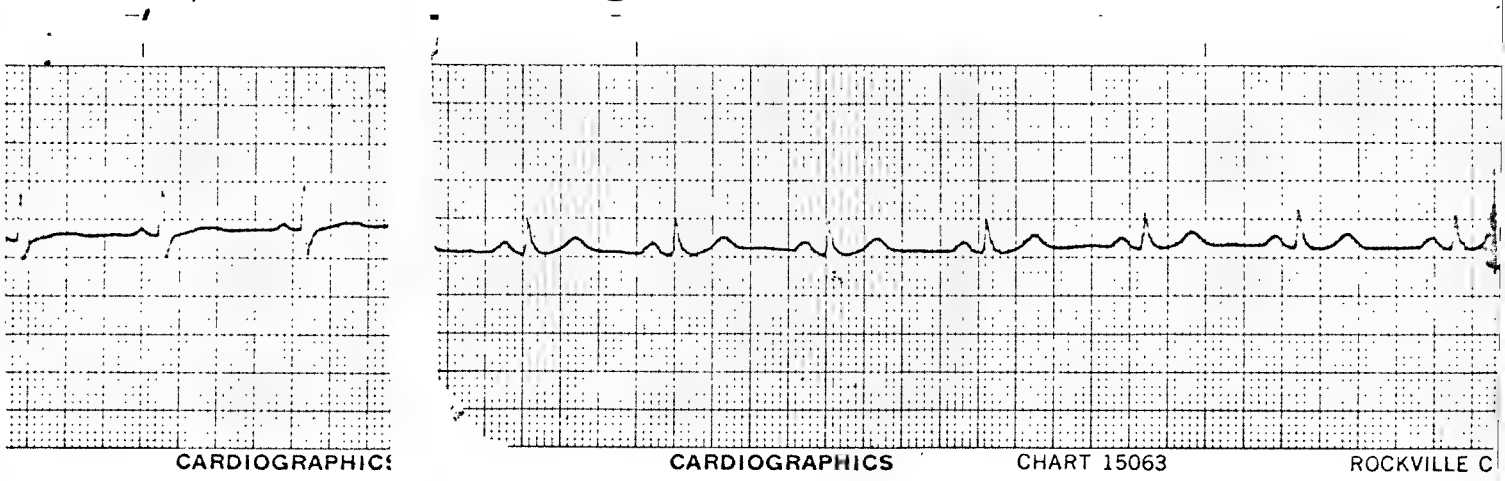
VENT. RATE P-R INT. S-T SEG.

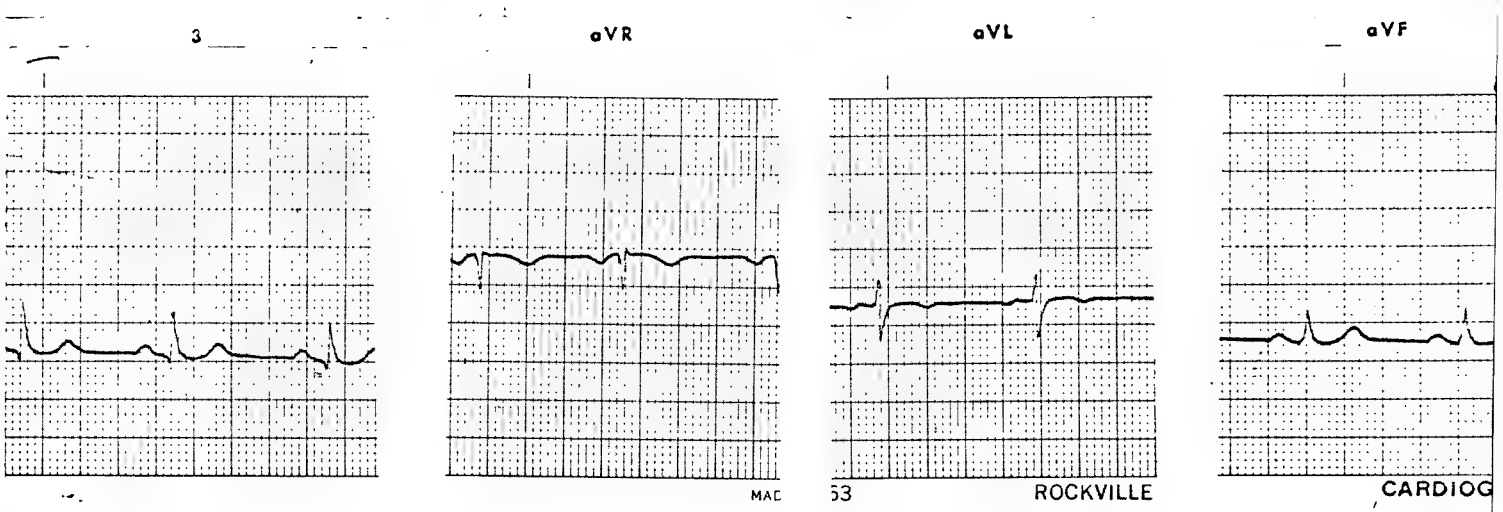
RHYTHM Q-R-S INT. T WAVES

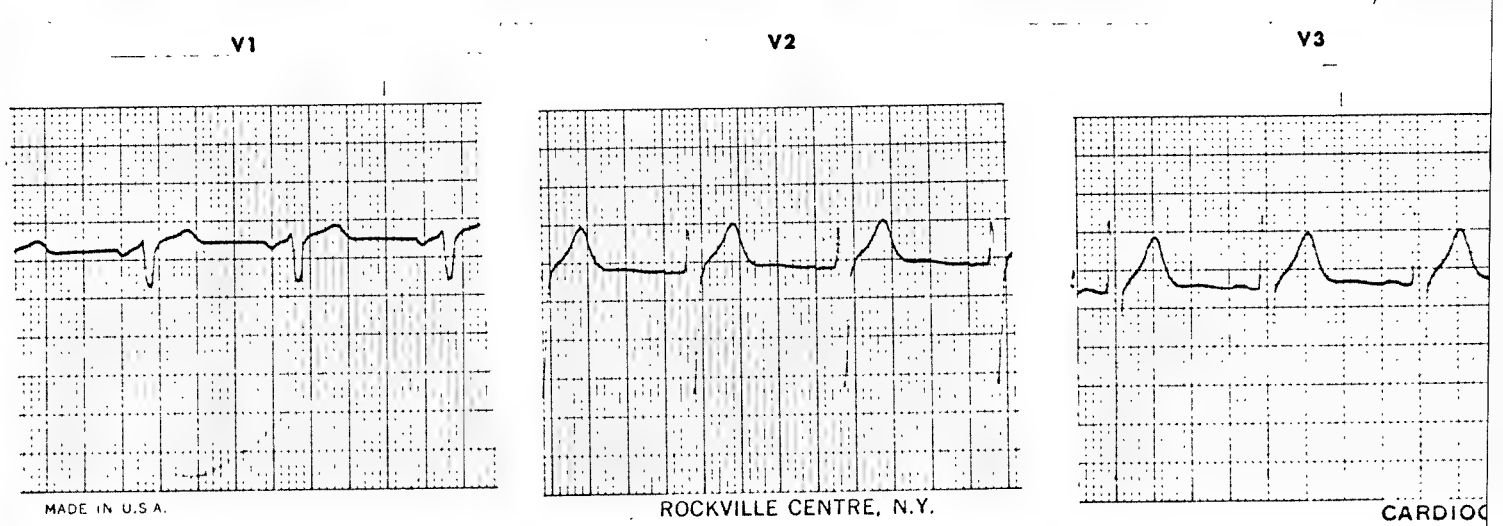
FINDINGS:

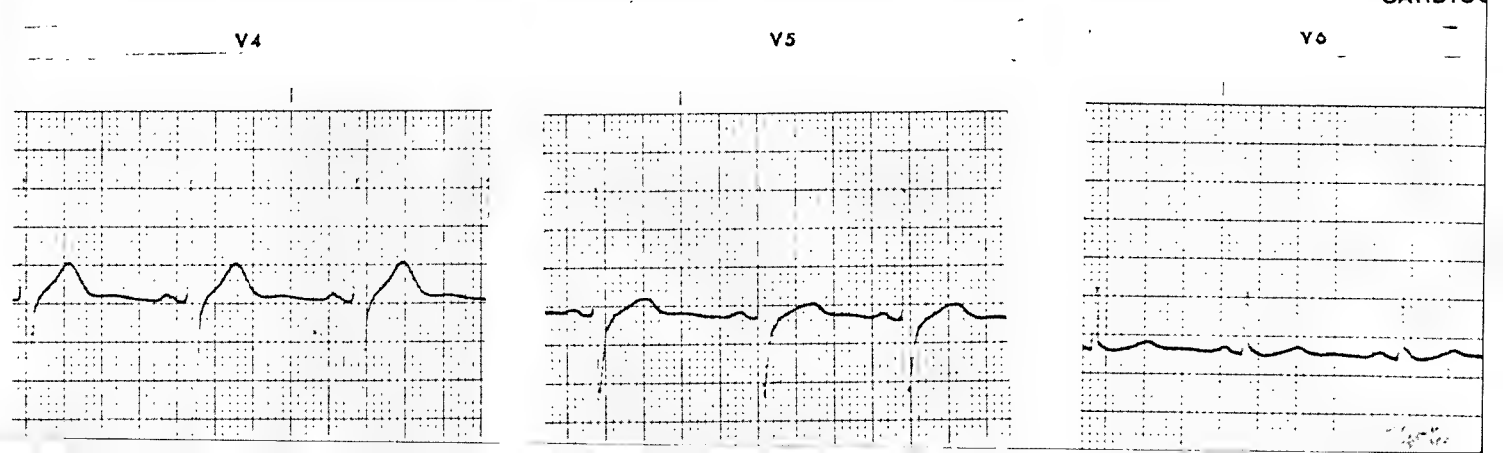
PATIENT

REMARKS: Within normal limits Takeuchi


1
2
CARDIOGRAPHICS
CARDIOGRAPHICS
CHART 15063
ROCKVILLE C


3
aVR
aVL
aVF
MAD
53
ROCKVILLE
CARDIOG


V1
V2
V3
MADE IN U.S.A.
ROCKVILLE CENTRE, N.Y.
CARDIOG


V4
V5
V6

CLINICAL RECORD — ELECTROCARDIOGRAPHIC RECORD

PREVIOUS ECG ☐ YES ☐ NO

CLINICAL IMPRESSION: S7.

MEDICATION: 0

☐ EMERGENCY ☐ ROUTINE ☐ BEDSIDE ☒ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B. P	SIGNATURE OF WARD PHYSICIAN	DATE
56	M	CAU	5'8"	165			

RHYTHM: SINUS

AXIS DEVIATION (QRS):

RATES — AURIC. VENT. 60

INTERVALS — PR 16 QRS 06 QT 36

P WAVES:

QRS COMPLEXES:

RS—T SEGMENT:

T WAVES:

UNIPOLAR EXTREMITY LEADS (*Specify*)

PRECORDIAL LEADS (*Specify*)

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

(1) BORDERLINE VOLTAGE FOR LVH

(2) REPEAT

(Continue on reverse)

NO. ECG	SIGNATURE OF PHYSICIAN	PATIENT'S IDENTIFICATION NO	DATE

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name, last, first, middle; grade; date; hospital or medical facility*)

A. JACOBY MERTON R.
343-65-3331

REGISTER NO.	WARD NO.
	PE

ELECTROCARDIOGRAPHIC RECORD
(Attach Tracings to SF-507)

Standard Form 520
Revised April 1968
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11-809-3
520-105

CLINICAL RECORD — ELECTROCARDIOGRAPHIC RECORD

PREVIOUS ECG ☐ YES ☐ NO

CLINICAL IMPRESSION	MEDICATION	☐ EMERGENCY ☐ ROUTINE	☐ BEDSIDE ☐ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B P	SIGNATURE OF WARD PHYSICIAN	DATE

RHYTHM	AXIS DEVIATION (QRS)	RATES AURIC VENT

INTERVALS PR QRS QT	P WAVES

QRS COMPLEXES

RS—T SEGMENT	T WAVES

UNIPOLAR EXTREMITY LEADS (*Specify*)

PRECORDIAL LEADS (*Specify*)

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS

(*Continue on reverse*)

NO ECG	SIGNATURE OF PHYSICIAN	PATIENT S IDENTIFICATION NO	DATE

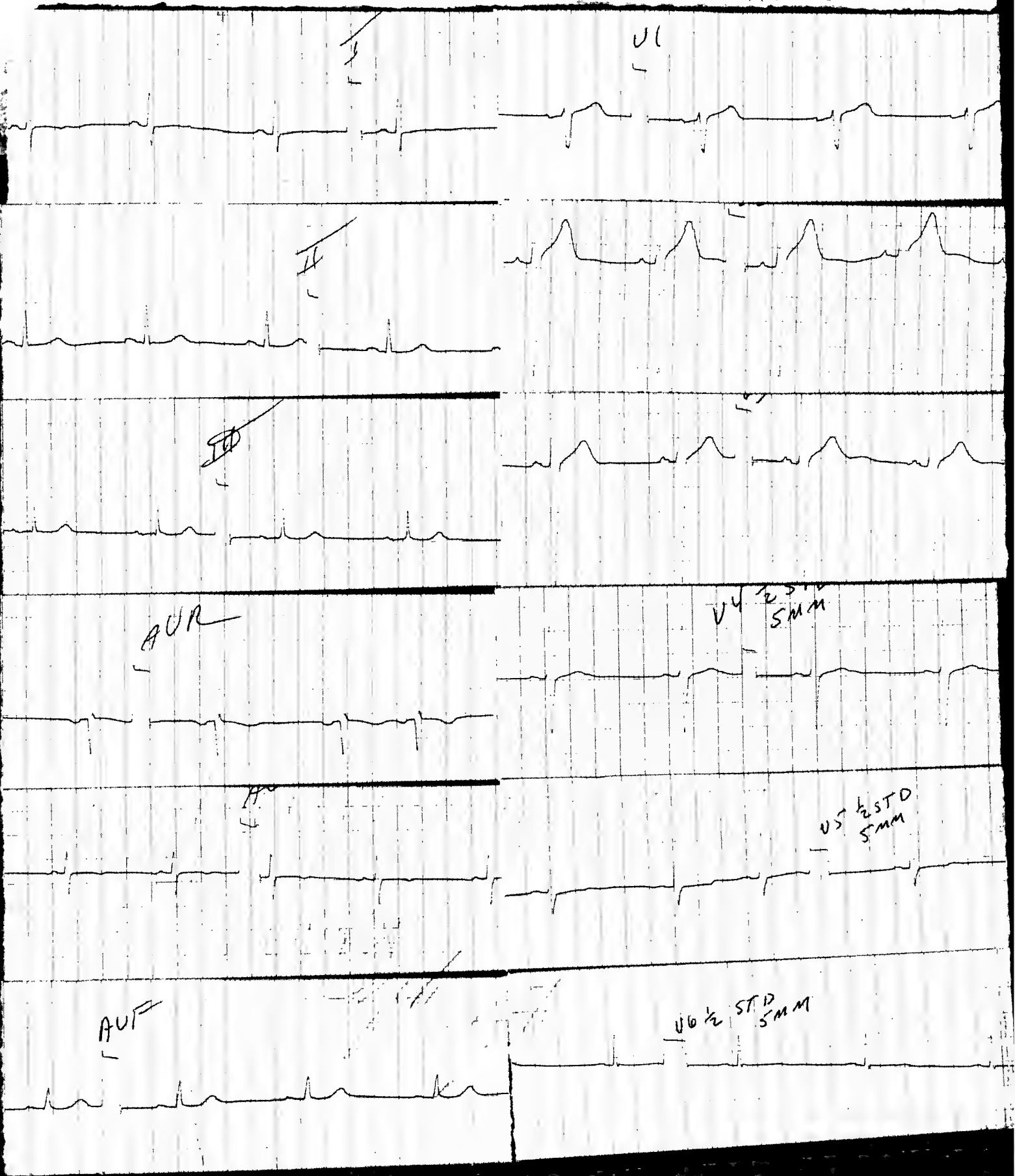
PATIENT'S IDENTIFICATION (*For typed or written entries give Name—last, first, middle, grade, date, hospital or medical facility*)	REGISTER NO	WARD NO

ELECTROCARDIOGRAPHIC RECORD

(Attach Tracings to SF–507)

Standard Form 520
Revised April 1968
General Services Administration &
Interagency Comm on Medical Records
FPMR 101–11–809–3
520–105

GPO 1969 O - 330-901


I
V1
II
III
AVR
V4 ½ STD 5MM
AVF
V5 ½ STD 5MM
V6 ½ STD 5MM

YES ☐ NO ☐

CLINICAL IMPRESSION: S.A.

MEDICATION: Ø

☐ EMERGENCY ☐ BEDSIDE
☐ ROUTINE ☐ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B P	SIGNATURE OF WARD PHYSICIAN	DATE
50	M	C	68	165		Dr Lazik	28 Apr 71

RHYTHM: SINUS

AXIS DEVIATION (QRS)

RATES: AURIC. VENT. 80

INTERVALS: PR 14 QRS 06 QT 32

P WAVES

QRS COMPLEXES

RS—T SEGMENT

T WAVES

UNIPOLAR EXTREMITY LEADS (*Specify*)

PRECORDIAL LEADS (*Specify*)

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS:

1) VOLTAGE FOR LVH

2) L VISCHEMIA.

(*Continue on reverse*)

NO ECG	SIGNATURE OF PHYSICIAN	PATIENT'S IDENTIFICATION NO	DATE

PATIENT'S IDENTIFICATION (*For typed or written entries give Name last, first, middle; grade, date, hospital or medical facility*)

ANDERSON, MERTON R.

393-05-3331

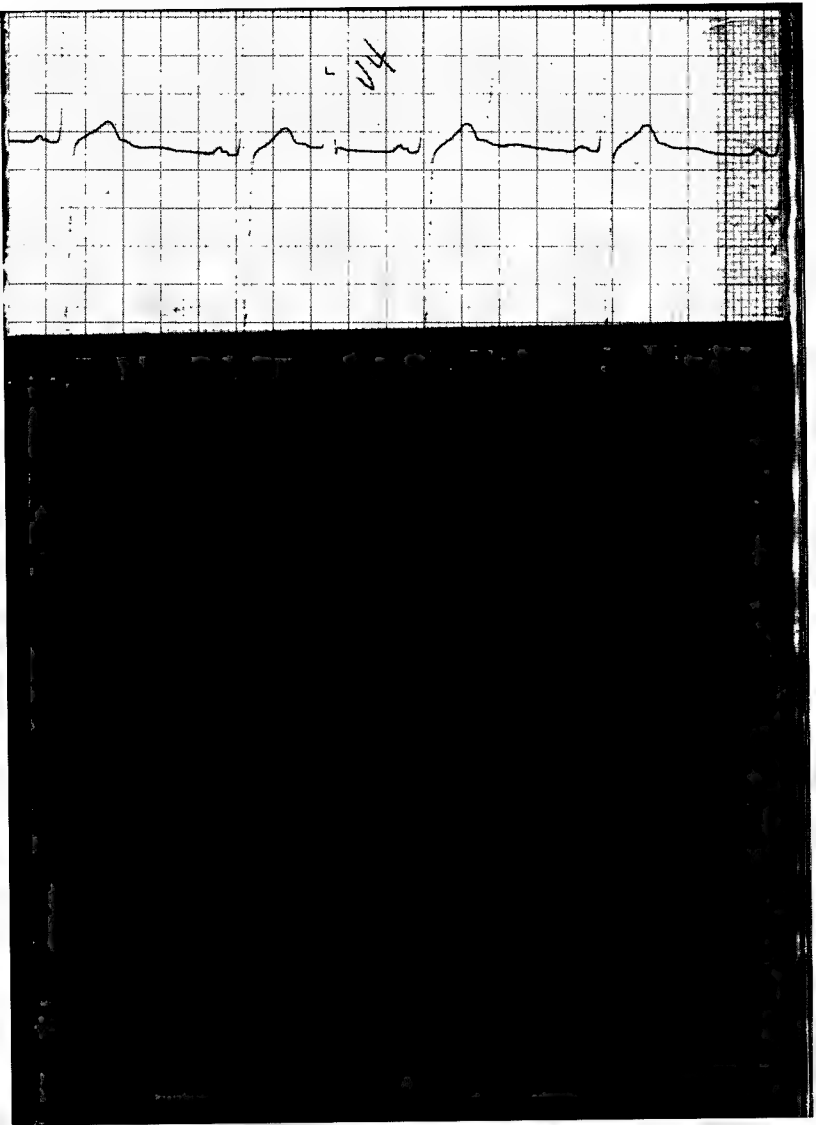
REGISTER NO

WARD NO. PE

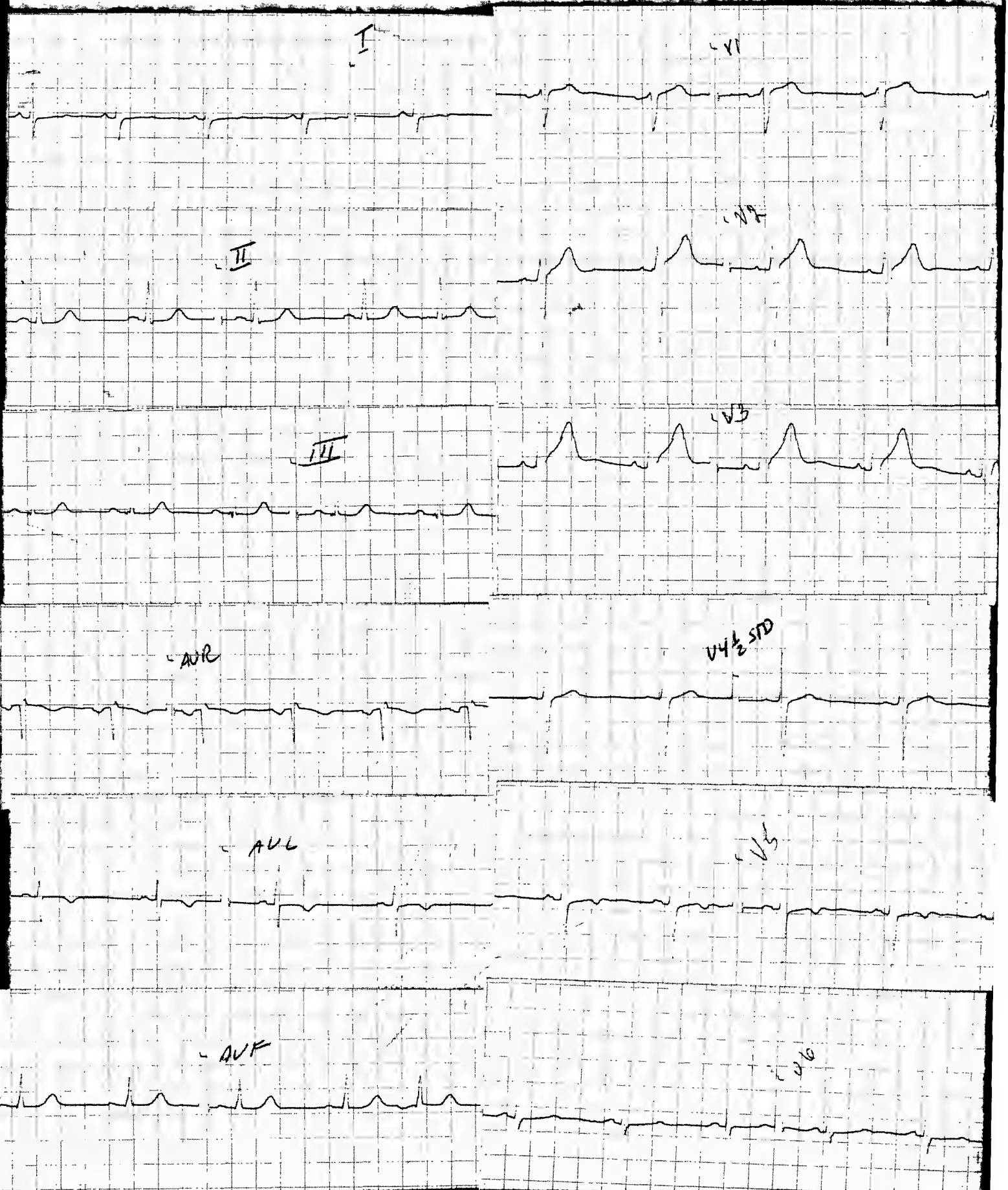
ELECTROCARDIOGRAPHIC RECORD

(Attach Tracings to SF-507)

Standard Form 520
Revised April 1968
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11-809-3
520-105


V4

CLINICAL RECORD ELECTROCARDIOGRAPHIC RECORD PREVIOUS ECG



Standard Form 513
Rev. August 1954
Bureau of the Budget
Circular A-32

U.S. GOVERNMENT PRINTING OFFICE : 1961 O—586373

CLINICAL RECORD — CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting ward, unit, or activity)	DATE OF REQUEST
INTERNAL MEDICINE	PHYSICAL EXAM SECTION MAFB	21 Jun 1971

REASON FOR REQUEST (*Complaints and findings*)

50 year old male FBI with abnormal EKG. Please evaluate.

PROVISIONAL DIAGNOSIS

As above

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
S. W. TURAY, CAPT, USAF, MC		☐ BEDSIDE ☐ ON CALL	☐ EMERGENCY ☐ ROUTINE

CONSULTATION REPORT

History of Present Illness: The patient is a 51-year-old asymptomatic Caucasian male Secret Service Agent who is referred to the Internal Medicine Clinic for evaluation of an abnormal routine electrocardiogram. The patient is totally asymptomatic and has had no historical evidence for cardiovascular, pulmonary, cerebral, renal or endocrine abnormalities, in spite of unlimited physical activities. Reportedly, routine physical examinations and electrocardiograms for the past 16 years have never been considered anything but normal. A routine electrocardiogram obtained at this facility in Apr 71 demonstrated a regular sinus rhythm with voltage criterion for left ventricular hypertrophy and T-wave inversion in the lateral precordial leads suggestive of left ventricular ischemia (i.e., abnormal repolarization compatible with the increased voltage). A repeat tracing was essentially the same. The patient's father age 76 is alive and well. His mother died at the age of 71 with a history of cerebrovascular, hypertensive, coronary artery and diabetic diseases. His sole sibling is alive and well.

Personal History: Allergies - None. Surgery - T&A. Medications - Niacin one tablet q.i.d. Smoking History - 30 pack years which was discontinued one year ago. Alcoholic Consumption - Minimal.

Systemic Review includes a questionable history of Meniere's disease diagnosed six years ago which has been optimally controlled with Niacin. The patient has never taken diuretics.

Family History is as noted above.

(*Continued on reverse side*)

SIGNATURE AND TITLE	DATE	IDENTIFICATION NO.	ORGANIZATION
ARTHUR J. LAZIK, MAJOR, USAF, MC	22Jun71	393-05-3331	FBI

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)	REGISTER NO.	WARD NO.
ANDERSON, MERTON R USAF REGIONAL HOSPITAL MARCH AFB CA		PE

Standard Form 507
(Revised August 1954)
Bureau of the Budget
Circular A-32

☆ U S GOVERNMENT PRINTING OFFICE 1961 O—587879

CLINICAL RECORD

Report on _____
or
Continuation of S. F. 513
(Strike out one line) (Specify type of examination or data)

(Sign and date)

Physical Examination: Blood pressure 146/88 in both arms in the sitting position. Pulse 90, strong and regular. General appearance is of an alert, well-toned, minimally overnourished, Caucasian male in no physical distress. The nails are pink and nonclubbed and there are no subcutaneous xanthomas. Head normocephalic. Pupils are equal, round and reactive to light with white sclera. Fundi disclose a venous arteriolar ratio of 3:2 with neither exudates nor hemorrhages. There is no arcus corneae nor xanthelasma. The oropharynx is devoid of lesions. Neck is supple with no venous distention in the sitting position or thyromegaly. Breath sounds are well-heard bilaterally with neither inspiratory rales nor expiratory wheezes. The cardiac apex is well-localized, nondisplaced and nonsustained. There are no palpable thrills or closure taps. Heart tones are good with a low intensity early ejection click heard loudest along the left sternal border. The second tone is physiologically split at the left base and, in addition, there are no murmurs, third heart sounds, fourth heart sounds or rubs. Abdomen is mildly overnourished without palpable viscera or tenderness. Genitalia is normal male. Muscle tone and power is excellent bilaterally with neither joint deformities or peripheral edema. The carotid, radial, femoral and dorsal pedal pulses are generous bilaterally without a time lag between the radial and femoral pulse. Cranial nerves, gait and sensorium are physiologic.

Comment: Although the electrocardiograms are electrically suggestive of left ventricular enlargement, I find absolutely no clinical, physical or radiologic findings suggestive of any cardiovascular abnormalities. In addition, a hematocrit was 49 volumes% with a normal routine urinalysis, normal chest x-ray and nonreactive serology. Unfortunately, previous EKG tracings are unavailable for comparison. At this juncture, I can only conclude that the patient has no overt evidence for cardiovascular disease and that obviously he be allowed complete and unlimited physical activities and that, in addition, no medications are indicated. However, I might suggest that routine blood pressures and electrocardiograms be obtained on a six month basis for at least the following year.

Diagnosis:
1. Electrocardiographic evidence for abnormally high voltage and T-wave changes suggestive of left ventricular enlargement and associated abnormal repolarization.
2. No historical, physical or radiologic findings confirming the above diagnosis.
3. Probably normal heart.

ARTHUR J. LAZIK, MAJOR, USAF, MC
22 Jun 71

(Continue on reverse side)

PATIENT'S IDENTIFICATION (Typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

ANDERSON, MERTON R.
USAF REGIONAL HOSPITAL, MARCH AFB CA

REGISTER NO. | WARD NO.

REPORT ON _____ or CONTINUATION OF SF 513

jmr

Budget Bureau
Approved 50-R0390

REPORT OF MEDICAL HISTORY

U.S. Civil Service Employees and Applicants

This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. TITLE OF POSITION	3. SOCIAL SECURITY NUMBER
ANDERSON, MERTON R.	SPECIAL AGENT	| |
4. HOME ADDRESS *(Number, street or RFD, city or town, State, and ZIP Code)*	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
1234 S. Broadmoor W. Covina, California	ANNUAL PHYSICAL	5 Apr 71

7. SEX	8. TOTAL YEARS GOVERNMENT SERVICE		9. AGENCY	10. ORGANIZATION UNIT
	MILITARY	CIVILIAN		
Male	3½	20	FBI	***

11. DATE OF BIRTH	12. PLACE OF BIRTH	13. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Including ZIP Code)*
7/21/20	Wisconsin Dells, Wisc.	USAF Regional Hospital March AFB, California

14. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

Good

15. DO YOU *(Please check at left of each item):*

YES	NO	*(Check each item)*
X		WEAR GLASSES OR CONTACT LENSES
X		HAVE VISION IN BOTH EYES
	X	WEAR A HEARING AID
	X	STUTTER OR STAMMER HABITUALLY
	X	WEAR A BRACE OR BACK SUPPORT

16. HAVE YOU EVER *(Please check at left of each item):*

YES	NO	*(Check each item)*
	X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	COUGHED UP BLOOD
	X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

17. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item):*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
	X		SCARLET FEVER, ERYSIPELAS		X		ASTHMA		X		RECENT GAIN OR LOSS OF WEIGHT
	X		DIPHTHERIA		X		SHORTNESS OF BREATH		X		ARTHRITIS OR RHEUMATISM
	X		RHEUMATIC FEVER		X		PAIN OR PRESSURE IN CHEST		X		BONE, JOINT, OR OTHER DEFORMITY
	X		SWOLLEN OR PAINFUL JOINTS		X		CHRONIC COUGH		X		LAMENESS
	X		MUMPS		X		PALPITATION OR POUNDING HEART		X		LOSS OF ARM, LEG, FINGER, OR TOE
	X		COLOR BLINDNESS		X		HIGH OR LOW BLOOD PRESSURE		X		PAINFUL OR "TRICK" SHOULDER OR ELBOW
	X		FREQUENT OR SEVERE HEADACHE		X		CRAMPS IN YOUR LEGS		X		RECURRENT BACK PAIN
	X		DIZZINESS OR FAINTING SPELLS		X		FREQUENT INDIGESTION		X		"TRICK" OR LOCKED KNEE
	X		EYE TROUBLE		X		STOMACH, LIVER, OR INTESTINAL TROUBLE		X		FOOT TROUBLE
X			EAR, NOSE, OR THROAT TROUBLE		X		GALL BLADDER TROUBLE OR GALLSTONES		X		NEURITIS
X			RUNNING EARS		X		JAUNDICE		X		PARALYSIS *(Inc. infantile)*
	X		HEARING LOSS		X		ANY ADVERSE REACTION TO SERUM, DRUG, OR MEDICINE		X		EPILEPSY OR FITS
	X		CHRONIC OR FREQUENT COLDS		X		BROKEN BONES		X		CAR, TRAIN, SEA, OR AIR SICKNESS
	X		SEVERE TOOTH OR GUM TROUBLE		X		TUMOR, GROWTH, CYST, OR CANCER		X		FREQUENT TROUBLE SLEEPING
	X		SINUSITIS		X		RUPTURE/HERNIA		X		FREQUENT OR TERRIFYING NIGHTMARES
	X		HAY FEVER		X		APPENDICITIS		X		DEPRESSION OR EXCESSIVE WORRY
	X		HEAD INJURY		X		PILES OR RECTAL DISEASE		X		LOSS OF MEMORY OR AMNESIA
	X		SKIN DISEASES		X		FREQUENT OR PAINFUL URINATION		X		NERVOUS TROUBLE OF ANY SORT
	X		GOITER		X		KIDNEY STONE OR BLOOD IN URINE		X		ANY DRUG OR NARCOTIC HABIT
	X		TUBERCULOSIS		X		SUGAR OR ALBUMIN IN URINE		X		EXCESSIVE DRINKING HABIT
	X		SOAKING SWEATS *(Night sweats)*		X		BOILS		X		PERIODS OF UNCONSCIOUSNESS

18. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	19. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	20. WHAT IS YOUR USUAL OCCUPATION?	21. ARE YOU *(Check one)*
One	Three years	Special Agent	[X] RIGHT HANDED [ ] LEFT HANDED

OPTIONAL FORM 58
MAY 1968
U.S. CIVIL SERVICE COMMISSION
FPM CHAPTER 293
5058-101

MRG

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
	X	22. HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.	
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS	
	X	D. OTHER MEDICAL REASONS *(If yes, give reasons)*	
	X	23. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?	
	X	24. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? *(If yes, state reason and give details)*	
X		25. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? *(If yes, describe and give age at which occurred)*	Army Air Force Hospital, Hondo, Texas, Tonsilectomy, January, 1943, age 22
X		26. HAVE YOU EVER BEEN A PATIENT IN ANY TYPE OF HOSPITAL? *(If yes, specify when, where, why, and name of doctor and complete address of hospital)*	See above, doctor unknown
	X	27. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? *(If yes, specify when, where, and give details)*	
	X	28. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS FOR OTHER THAN MINOR ILLNESSES? *(If yes, give complete address of doctor, hospital, clinic, and details)*	
	X	29. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date and reason for rejection)*	
	X	30. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability)*	
	X	31. HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? *(If yes, specify what kind, granted by whom, and what amount, when, why)*	

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R. Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

32. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 15 through 31. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1968 OF—300-463 (44-H)

ANDERSON MERTON R

NAME _____ DATE SEP 4 1972 CODE _____

ADDRESS _____

TEL. NO. _____ OCCUPATION FBI

AGE 51 SEX M. HT. _____ WT. _____ B.P. _____

PHYSICIAN Dr Super

HISTORY _____

DIGITALIS _____ QUINIDINE _____ OTHER _____ PAT. POS. _____

AURIC. RATE _____ P WAVES _____ Q-T INT. _____

VENT. RATE _____ P-R INT. _____ S-T SEG. _____

RHYTHM _____ Q-R-S INT. _____ T WAVES _____

FINDINGS: _____

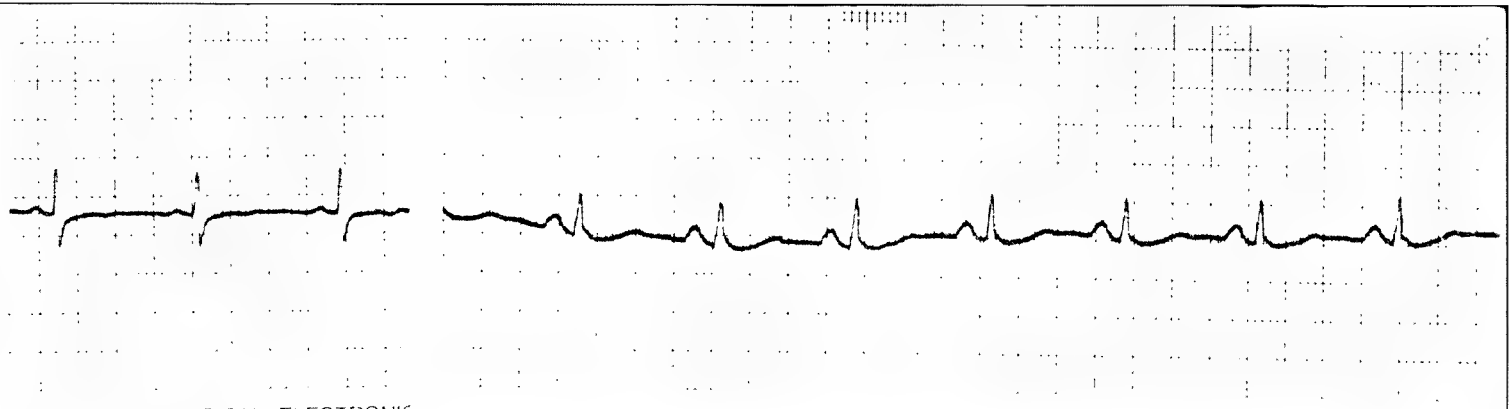
Abnormal

REMARKS: II L V H by voltage & ST-T abnormality.

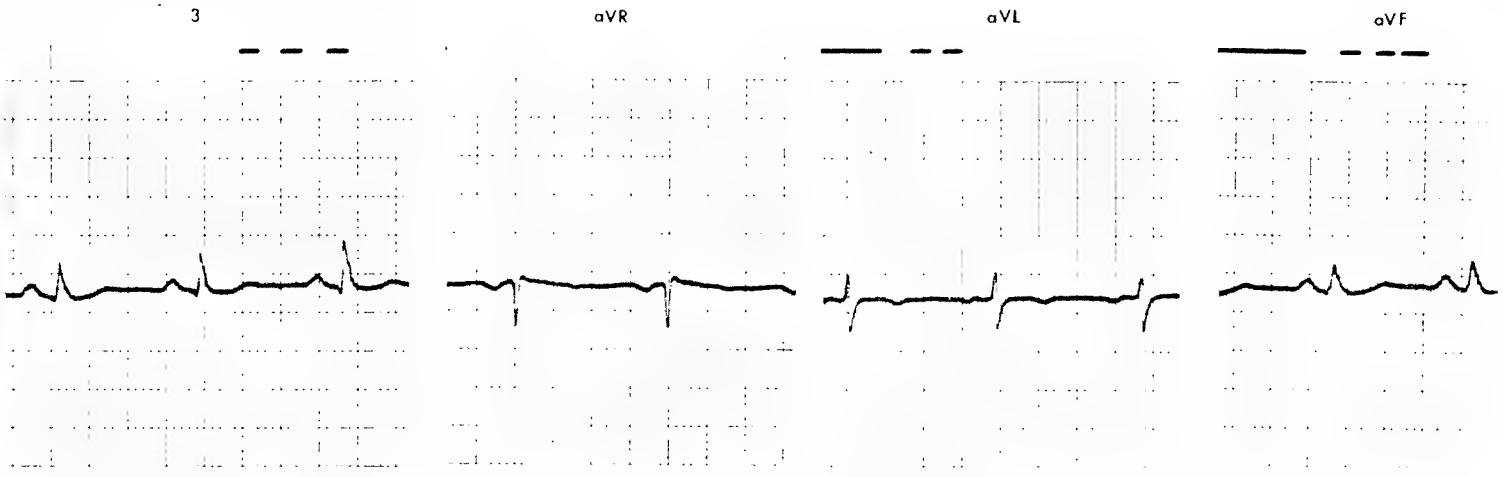
Annette

PATIENT

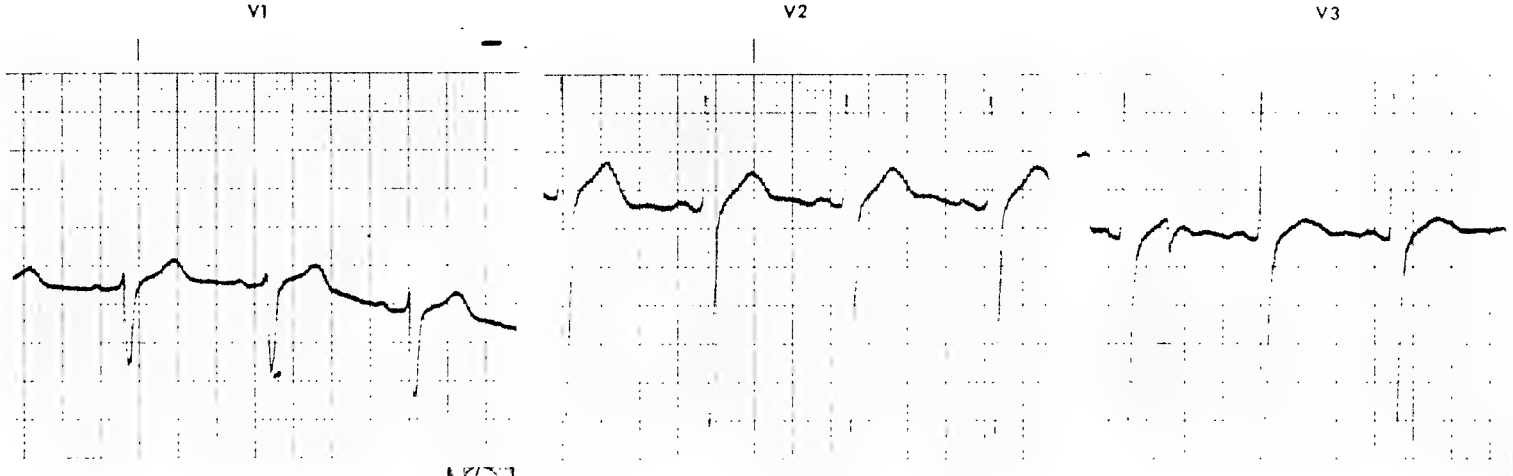
U. S. P[illegible] Health Service
Outpati[illegible]
825 Sou[illegible] St.
San Pedro, California 90731



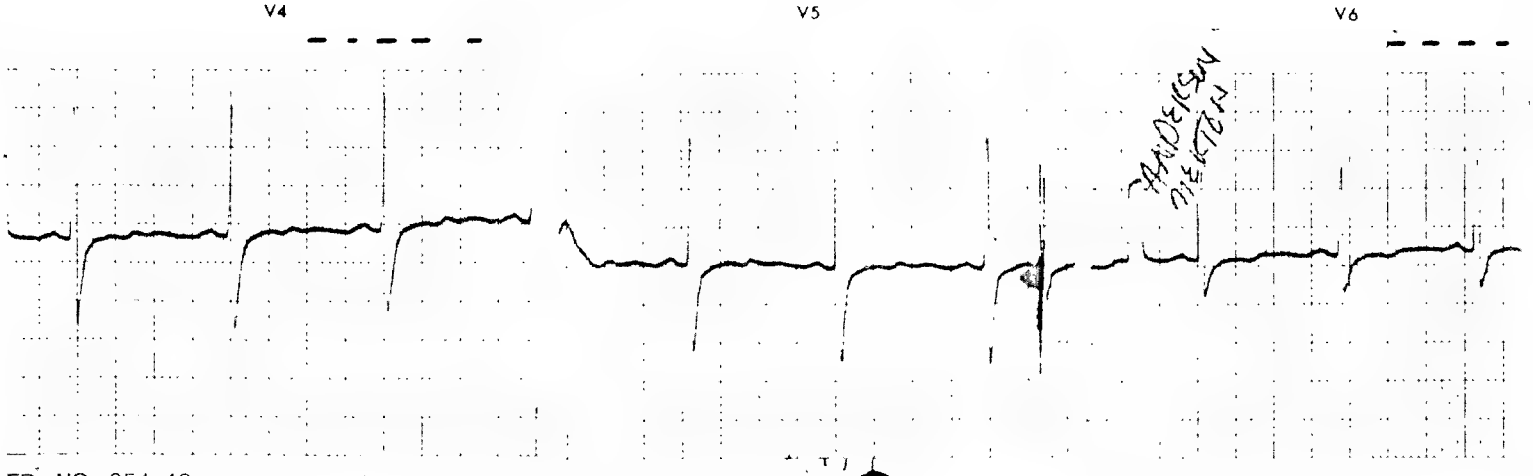
• PACKARD MEDICAL ELECTRONIC



PERMAPAPER NO. 651-40 L ELECTRONICS DIVISION



DIVISION PERMAPAPER NO. 651-40



ER NO. 651-40

Budget Bureau
Approved 50-R0390

REPORT OF MEDICAL HISTORY

U.S. Civil Service Employees and Applicants

This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. TITLE OF POSITION	3. SOCIAL SECURITY NUMBER
ANDERSON, MERTON R.	SPECIAL AGENT	393 05 8331
4. HOME ADDRESS *(Number, street or RFD, city or town, State, and ZIP Code)*	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
11000 Wilshire Boulevard Los Angeles, California	ANNUAL PHYSICAL	4/4/72

7. SEX	8. TOTAL YEARS GOVERNMENT SERVICE		9. AGENCY	10. ORGANIZATION UNIT
	MILITARY	CIVILIAN		
Male	3½	21	FBI	***

11. DATE OF BIRTH	12. PLACE OF BIRTH	13. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Including ZIP Code)*
7/21/20	Wisconsin Dells, Wisc.	U S PUBLIC HEALTH San Pedro, California

14. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

Good

15. DO YOU *(Please check at left of each item):*			16. HAVE YOU EVER *(Please check at left of each item):*		
YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
X		WEAR GLASSES OR CONTACT LENSES		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
X		HAVE VISION IN BOTH EYES		X	COUGHED UP BLOOD
	X	WEAR A HEARING AID		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION
	X	STUTTER OR STAMMER HABITUALLY			
	X	WEAR A BRACE OR BACK SUPPORT			

17. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item):*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
	X		SCARLET FEVER, ERYSIPELAS		X		ASTHMA		X		RECENT GAIN OR LOSS OF WEIGHT
	X		DIPHTHERIA		X		SHORTNESS OF BREATH		X		ARTHRITIS OR RHEUMATISM
	X		RHEUMATIC FEVER		X		PAIN OR PRESSURE IN CHEST		X		BONE, JOINT, OR OTHER DEFORMITY
	X		SWOLLEN OR PAINFUL JOINTS		X		CHRONIC COUGH		X		LAMENESS
	X		MUMPS		X		PALPITATION OR POUNDING HEART		X		LOSS OF ARM, LEG, FINGER, OR TOE
	X		COLOR BLINDNESS		X		HIGH OR LOW BLOOD PRESSURE		X		PAINFUL OR "TRICK" SHOULDER OR ELBOW
	X		FREQUENT OR SEVERE HEADACHE		X		CRAMPS IN YOUR LEGS		X		RECURRENT BACK PAIN
	X		DIZZINESS OR FAINTING SPELLS		X		FREQUENT INDIGESTION		X		"TRICK" OR LOCKED KNEE
	X		EYE TROUBLE		X		STOMACH, LIVER, OR INTESTINAL TROUBLE		X		FOOT TROUBLE
X			EAR, NOSE, OR THROAT TROUBLE		X		GALL BLADDER TROUBLE OR GALLSTONES		X		NEURITIS
X			RUNNING EARS		X		JAUNDICE		X		PARALYSIS *(Inc. infantile)*
	X		HEARING LOSS		X		ANY ADVERSE REACTION TO SERUM, DRUG, OR MEDICINE		X		EPILEPSY OR FITS
	X		CHRONIC OR FREQUENT COLDS		X		BROKEN BONES		X		CAR, TRAIN, SEA, OR AIR SICKNESS
	X		SEVERE TOOTH OR GUM TROUBLE		X		TUMOR, GROWTH, CYST, OR CANCER		X		FREQUENT TROUBLE SLEEPING
	X		SINUSITIS		X		RUPTURE/HERNIA		X		FREQUENT OR TERRIFYING NIGHTMARES
	X		HAY FEVER		X		APPENDICITIS		X		DEPRESSION OR EXCESSIVE WORRY
	X		HEAD INJURY		X		PILES OR RECTAL DISEASE		X		LOSS OF MEMORY OR AMNESIA
	X		SKIN DISEASES		X		FREQUENT OR PAINFUL URINATION		X		NERVOUS TROUBLE OF ANY SORT
	X		GOITER		X		KIDNEY STONE OR BLOOD IN URINE		X		ANY DRUG OR NARCOTIC HABIT
	X		TUBERCULOSIS		X		SUGAR OR ALBUMIN IN URINE		X		EXCESSIVE DRINKING HABIT
	X		SOAKING SWEATS *(Night sweats)*		X		BOILS		X		PERIODS OF UNCONSCIOUSNESS

18. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	19. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	20. WHAT IS YOUR USUAL OCCUPATION?	21. ARE YOU *(Check one)*
one	Three years MONTHS	Special Agent	[X] RIGHT HANDED [ ] LEFT HANDED

OPTIONAL FORM 58
MAY 1968
U.S. CIVIL SERVICE COMMISSION
FPM CHAPTER 293
5058-101

MRA

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
	X	22. HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.	
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS	
	X	D. OTHER MEDICAL REASONS *(If yes, give reasons)*	
	X	23. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?	
	X	24. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? *(If yes, state reason and give details)*	
X		25. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? *(If yes, describe and give age at which occurred)*	Army Air Force Hospital, Hondo, Texas Tonsilectomy, January, 1943, Age 22
X		26. HAVE YOU EVER BEEN A PATIENT IN ANY TYPE OF HOSPITAL? *(If yes, specify when, where, why, and name of doctor and complete address of hospital)*	See above, doctor unknown
	X	27. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? *(If yes, specify when, where, and give details)*	
	X	28. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS FOR OTHER THAN MINOR ILLNESSES? *(If yes, give complete address of doctor, hospital, clinic, and details)*	
	X	29. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date and reason for rejection)*	
	X	30. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability)*	
	X	31. HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? *(If yes, specify what kind, granted by whom, and what amount, when, why)*	

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R. Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

32. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 15 through 31. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
GREG SUPER, M.D., SURGEON (R)	4/4/72.	G. Super, M.D.	

U.S. GOVERNMENT PRINTING OFFICE : 1968 OF—300-463 (44-H)

NAME FBIP 21 20 M DATE MAR 30 1973 CODE

ADDRESS

ANDERSON, MERTON R.

TEL. NO. OCCUPATION FBI

AGE 52 SEX M HT. WT. B.P.

PHYSICIAN Dr. Bagley

HISTORY

DIGITALIS QUINIDINE OTHER PAT. POS.

AURIC. RATE P WAVES Q-T INT.

VENT. RATE P-R INT. S-T SEG.

RHYTHM Q-R-S INT. T WAVES

FINDINGS

PATIENT

U. S. Public Health Service
Outpatient Clinic
825 South Beacon St.
San Pedro, California 90731

REMARKS Basic 4/72 unipolar ST-T abnorm

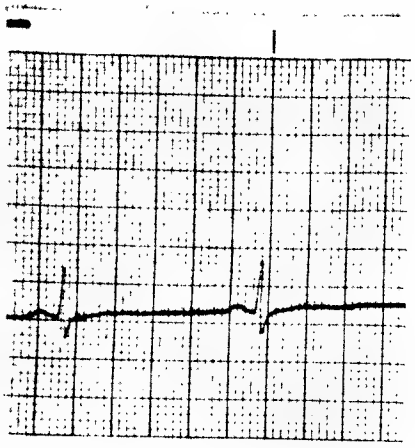
w/ no long axis for LVH

how ofs minn IN & ST T D's

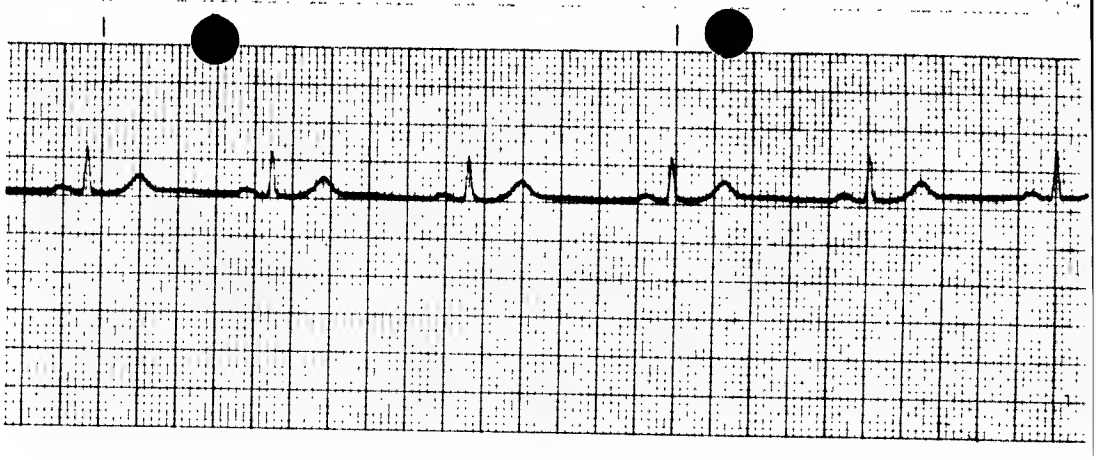
otherwise WNL

Anterior

B



NO. ECG 100



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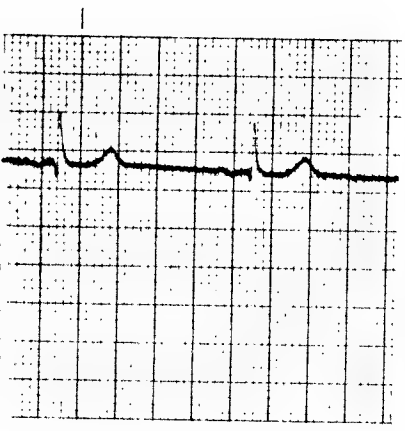

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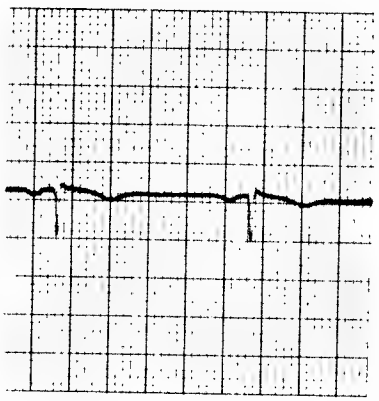

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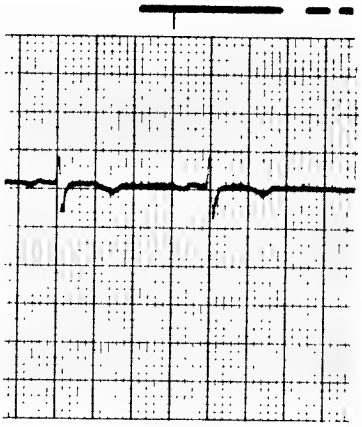

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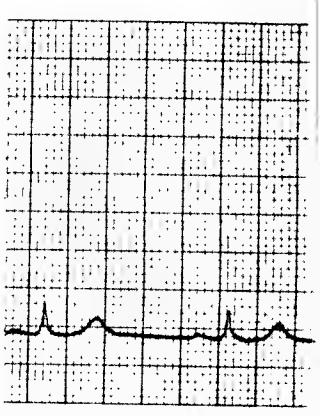
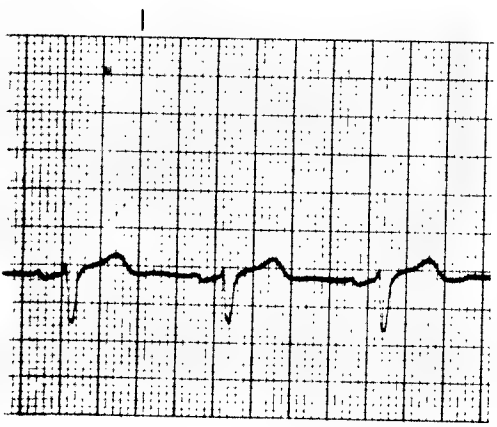


V1



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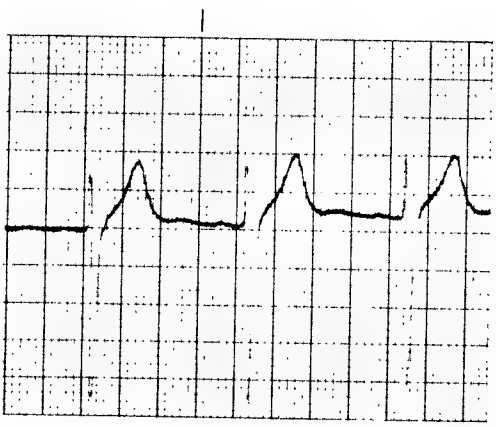

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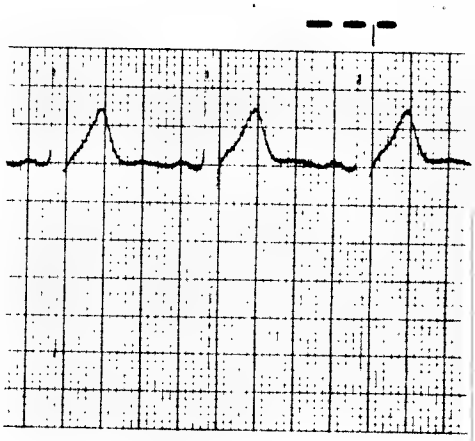

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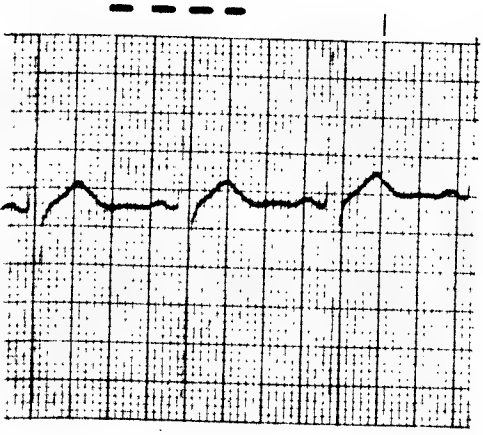

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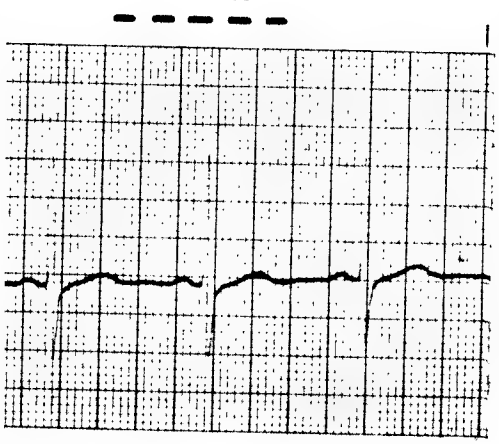

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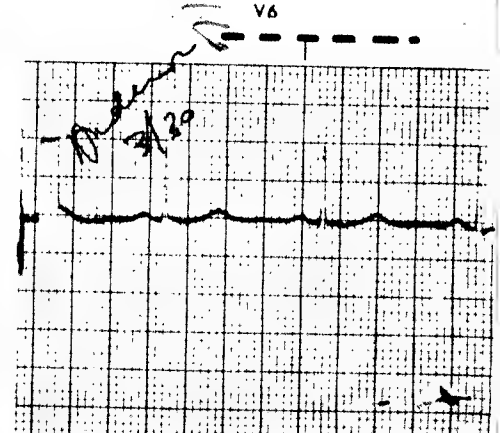


STANDARD FORM 93
JANUARY 1971
GSA FPMR 101–11.8

Approved
Office of Management and Budget No. 29–R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
ANDERSON, MERTON R.	393 05 3331
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*	**4. POSITION** *(Title, grade, component)*
11000 Wilshire Boulevard Los Angeles, California	SPECIAL AGENT

5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
ANNUAL PHYSICAL	3/30/73	U S PUBLIC HEALTH San Pedro, California

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

Health - Good - no medications currently being taken

9. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
X		Wear glasses or contact lenses
X		Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever, erysipelas
	X		Rheumatic fever
	X		Swollen or painful joints
	X		Frequent or severe headache
	X		Dizziness or fainting spells
	X		Eye trouble
X			Ear, nose, or throat trouble
	X		Hearing loss
	X		Chronic or frequent colds
	X		Severe tooth or gum trouble
	X		Sinusitis
	X		Hay Fever
	X		Head injury
	X		Skin diseases
	X		Thyroid trouble
	X		Tuberculosis
	X		Asthma
	X		Shortness of breath
	X		Pain or pressure in chest
	X		Chronic cough
	X		Palpitation or pounding heart
	X		Heart trouble
	X		High or low blood pressure

YES	NO	DON'T KNOW	(Check each item)
	X		Cramps in your legs
	X		Frequent indigestion
	X		Stomach, liver, or intestinal trouble
	X		Gall bladder trouble or gallstones
	X		Jaundice or hepatitis
	X		Adverse reaction to serum, drug, or medicine
	X		Frequent trouble sleeping
	X		Broken bones
	X		Tumor, growth, cyst, cancer
	X		Rupture/hernia
	X		Piles or rectal disease
	X		Frequent or painful urination
	X		Bed wetting since age 12
	X		Kidney stone or blood in urine
	X		Sugar or albumin in urine
	X		VD—Syphilis, gonorrhea, etc.
	X		Recent gain or loss of weight
	X		Arthritis, Rheumatism, or Bursitis
	X		Bone, joint or other deformity
	X		Lameness
	X		Loss of finger or toe
	X		Painful or "trick" shoulder or elbow
	X		Recurrent back pain

YES	NO	DON'T KNOW	(Check each item)
	X		"Trick" or locked knee
	X		Foot trouble
	X		Neuritis
	X		Paralysis (include infantile)
	X		Epilepsy or fits
	X		Car, train, sea or air sickness
	X		Frequent trouble sleeping
	X		Depression or excessive worry
	X		Loss of memory or amnesia
	X		Nervous trouble of any sort
	X		Periods of unconsciousness

12. FEMALES ONLY: HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

Special Agent

14. ARE YOU *(Check one)*

[X] Right handed [ ] Left handed

93–101

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
	X	B. Inability to perform certain motions.
	X	C. Inability to assume certain positions.
	X	D. Other medical reasons (*If yes, give reasons.*)
	X	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details).*
	X	17. Have you ever been denied life insurance? (*If yes, state reason and give details.)*
	X	18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.)* Tonsillectomy Army Air Force Hospital, Hondo, Texas January, 1943, Age 22 Doctor Unknown
	X	19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.)*
	X	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.)*
	X	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.)*
	X	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.)*
	X	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)*
	X	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.)*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
FREDERICK H. BAGLEY, M.D., S.A. SURGEON (R)	3-30-43	F H Bagley MD	

REVERSE OF STANDARD FORM 93

GPO : 1971 O - 419-271

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101–11.8

Approved
Office of Management and Budget No. 29–R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
ANDERSON, MERTON R.	393 05 3331
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*	**4. POSITION** *(Title, grade, component)*
11000 Wilshire Boulevard Los Angeles, California	SPECIAL AGENT

5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
ANNUAL PHYSICAL	3/27/74	U S PUBLIC HEALTH San Pedro, California

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

Health - good no medications currently being taken

9. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	*(Check each item)*
X		Wear glasses or contact lenses
X		Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
	X		Scarlet fever, erysipelas		X		Cramps in your legs		X		"Trick" or locked knee
	X		Rheumatic fever		X		Frequent indigestion		X		Foot trouble
	X		Swollen or painful joints		X		Stomach, liver, or intestinal trouble		X		Neuritis
	X		Frequent or severe headache		X		Gall bladder trouble or gallstones		X		Paralysis (include infantile)
	X		Dizziness or fainting spells		X		Jaundice or hepatitis		X		Epilepsy or fits
	X		Eye trouble		X		Adverse reaction to serum, drug,		X		Car, train, sea or air sickness
X			Ear, nose, or throat trouble				or medicine		X		Frequent trouble sleeping
	X		Hearing loss		X		Broken bones		X		Depression or excessive worry
	X		Chronic or frequent colds		X		Tumor, growth, cyst, cancer		X		Loss of memory or amnesia
	X		Severe tooth or gum trouble		X		Rupture/hernia		X		Nervous trouble of any sort
	X		Sinusitis		X		Piles or rectal disease		X		Periods of unconsciousness
	X		Hay Fever		X		Frequent or painful urination				
	X		Head injury		X		Bed wetting since age 12				
	X		Skin diseases		X		Kidney stone or blood in urine				
	X		Thyroid trouble		X		Sugar or albumin in urine				
	X		Tuberculosis		X		VD—Syphilis, gonorrhea, etc.				
	X		Asthma		X		Recent gain or loss of weight				
	X		Shortness of breath		X		Arthritis, Rheumatism, or Bursitis				
	X		Pain or pressure in chest		X		Bone, joint or other deformity				
	X		Chronic cough		X		Lameness				
	X		Palpitation or pounding heart		X		Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
	X		Heart trouble		X		Painful or "trick" shoulder or elbow				Been treated for a female disorder
	X		High or low blood pressure		X		Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

Special Agent

14. ARE YOU *(Check one)*

[X] Right handed [ ] Left handed

93–101

b6
b7C

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
	X	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.	
	X	B. Inability to perform certain motions.	
	X	C. Inability to assume certain positions.	
	X	D. Other medical reasons (*If yes, give reasons.*)	
	X	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details).*	
	X	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)	
X		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)	See below
X		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)	Tonsillectomy Army Air Force Hospital, Hondo, Texas, January, 1943, Age 22, Doctor Unknown
	X	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)	
	X	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)	
	X	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)	
	X	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)	
	X	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Merton R. Anderson	Merton R. Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

ENT- has had mild dizziness
R for pres by ENT-MD.

b6
b7C

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIG	NUMBER OF ATTACHED SHEETS
[redacted]	4/1/74	[redacted]	

REVERSE OF STANDARD FORM 93

GPO : 1971 O - 419-271

7 6 1 9

NAME ANDERSEN-HURTOK R DATE APR 1 1974 CODE

FBI

7 81 80 11

ADDRESS

TEL. NO. OCCUPATION FBI

AGE 53 SEX Male HT. WT. B.P.

b6
b7C

PHYSICIAN [redacted]

HISTORY

DIGITALIS QUINIDINE OTHER PAT. POS.

AURIC. RATE P WAVES Q-T INT.

VENT. RATE P-R INT. S-T SEG.

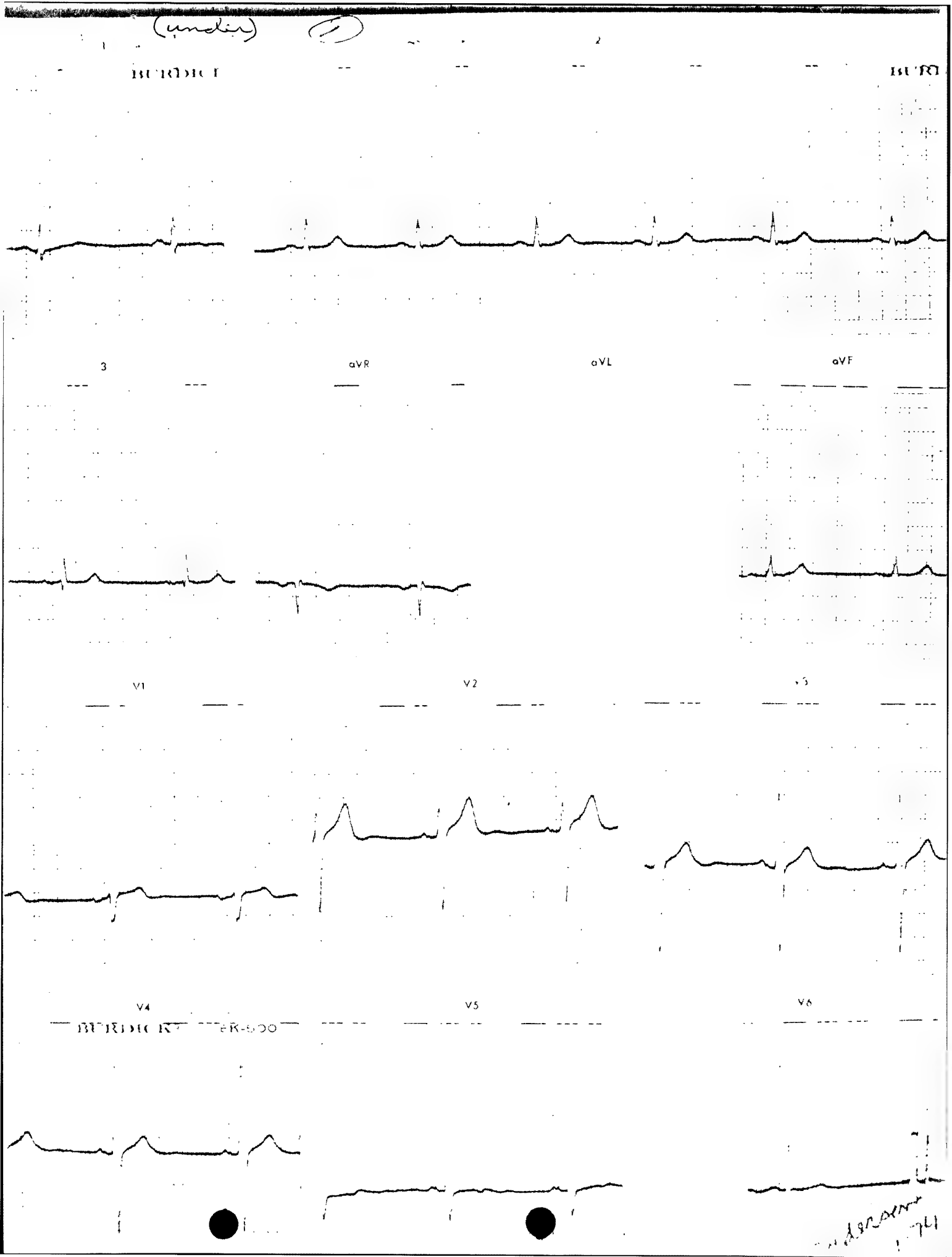
RHYTHM Q-R-S INT. T WAVES

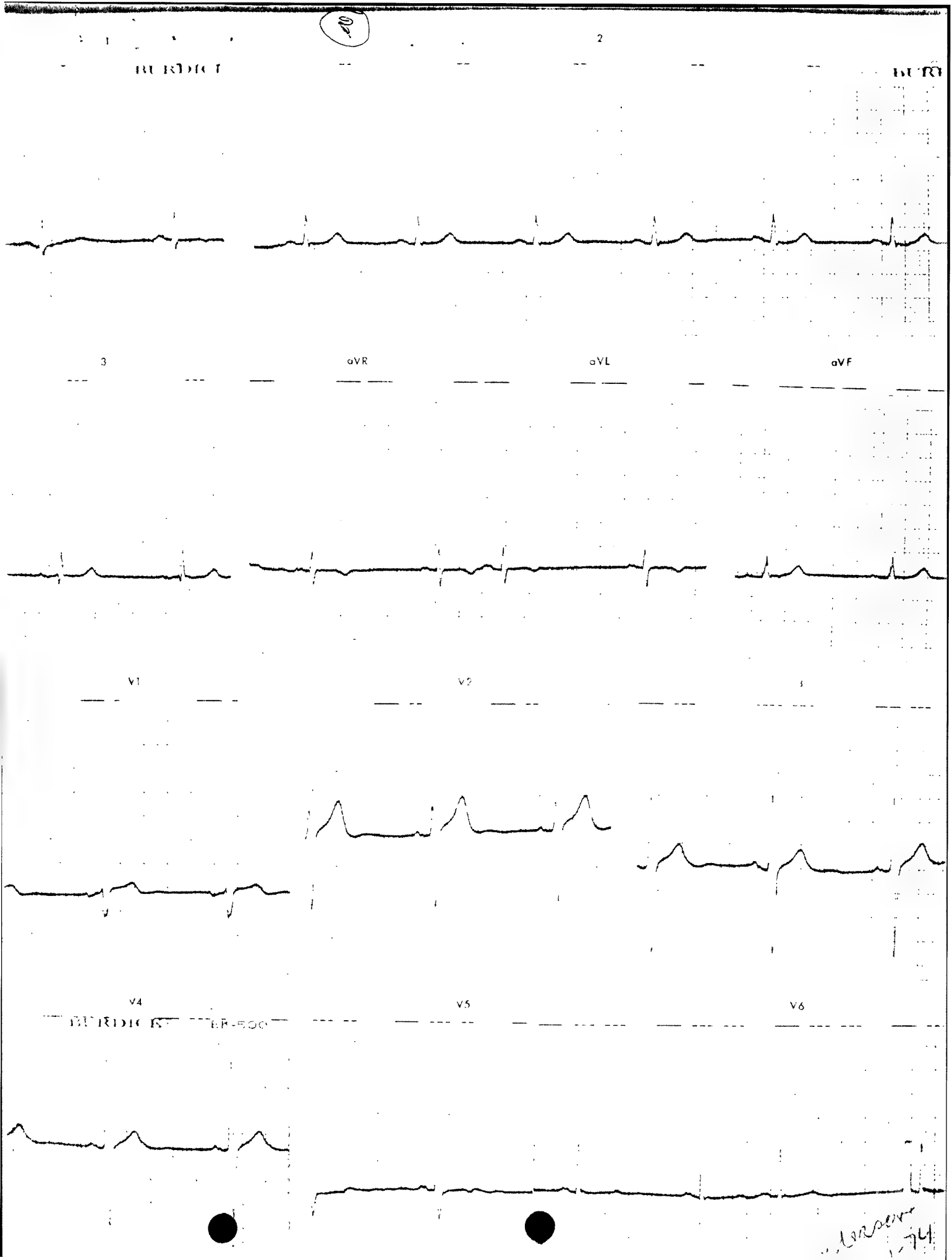
FINDINGS: ~~[illegible]~~ Sinus Arrhythmia
Leo HPCs
Minor NSST-TA.

REMARKS:

PATIENT

(undiv)

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II
III
aVR
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V1
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V3
V4
V5
V6

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101-11.8

Approved
Office of Management and Budget No. 29-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME: ANDERSON, MERTON R.

2. SOCIAL SECURITY OR IDENTIFICATION NO.: 303 05 3331

3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE): 11000 Wilshire Boulevard
Los Angeles, California

4. POSITION (City, grade, component): SPECIAL AGENT

5. PURPOSE OF EXAMINATION: ANNUAL PHYSICAL

6. DATE OF EXAMINATION: 3/31/75

7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code): U. S. PUBLIC HEALTH
San Pedro, California

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

Head

9. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

10. DO YOU (Please check each item)

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever, erysipelas
	✓		Rheumatic fever
	✓		Swollen or painful joints
	✓		Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
			Ear, nose, or throat trouble
	✓		Hearing loss
	✓		Chronic or frequent colds
	✓		Severe tooth or gum trouble
	✓		Sinusitis
	✓		Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
	✓		Shortness of breath
	✓		Pain or pressure in chest
	✓		Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure

YES	NO	DON'T KNOW	(Check each item)
	✓		Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach liver or intestinal trouble
	✓		Gall bladder trouble or gallstones
	✓		Jaundice or hepatitis
	✓		Adverse reaction to serum, drug, or medicine
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture hernia
	✓		Piles or rectal disease
	✓		Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
	✓		Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
	✓		Recent gain or loss of weight
	✓		Arthritis, Rheumatism or Bursitis
	✓		Bone, joint or other deformity
	✓		Lameness
	✓		Loss of finger or toe
	✓		Painful or "trick" shoulder or elbow
	✓		Recurrent back pain

YES	NO	DON'T KNOW	(Check each item)
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
	✓		Frequent trouble sleeping
	✓		Depression or excessive worry
	✓		Loss of memory or amnesia
	✓		Nervous trouble of any sort
	✓		Periods of unconsciousness

12. FEMALES ONLY: HAVE YOU EVER

		(Check each item)
		Been treated for a female disorder
		Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU (Check one)

☑ Right handed ☐ b6 b7C handed

93-101

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	✓	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
	✓	B. Inability to perform certain motions.
	✓	C. Inability to assume certain positions.
	✓	D. Other medical reasons (*If yes, give reasons.*)
	✓	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details*).
	✓	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
✓		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
✓		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
	✓	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
	✓	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
	✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
	✓	23 Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)
	✓	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
[illegible]	[illegible]

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

Hx as above

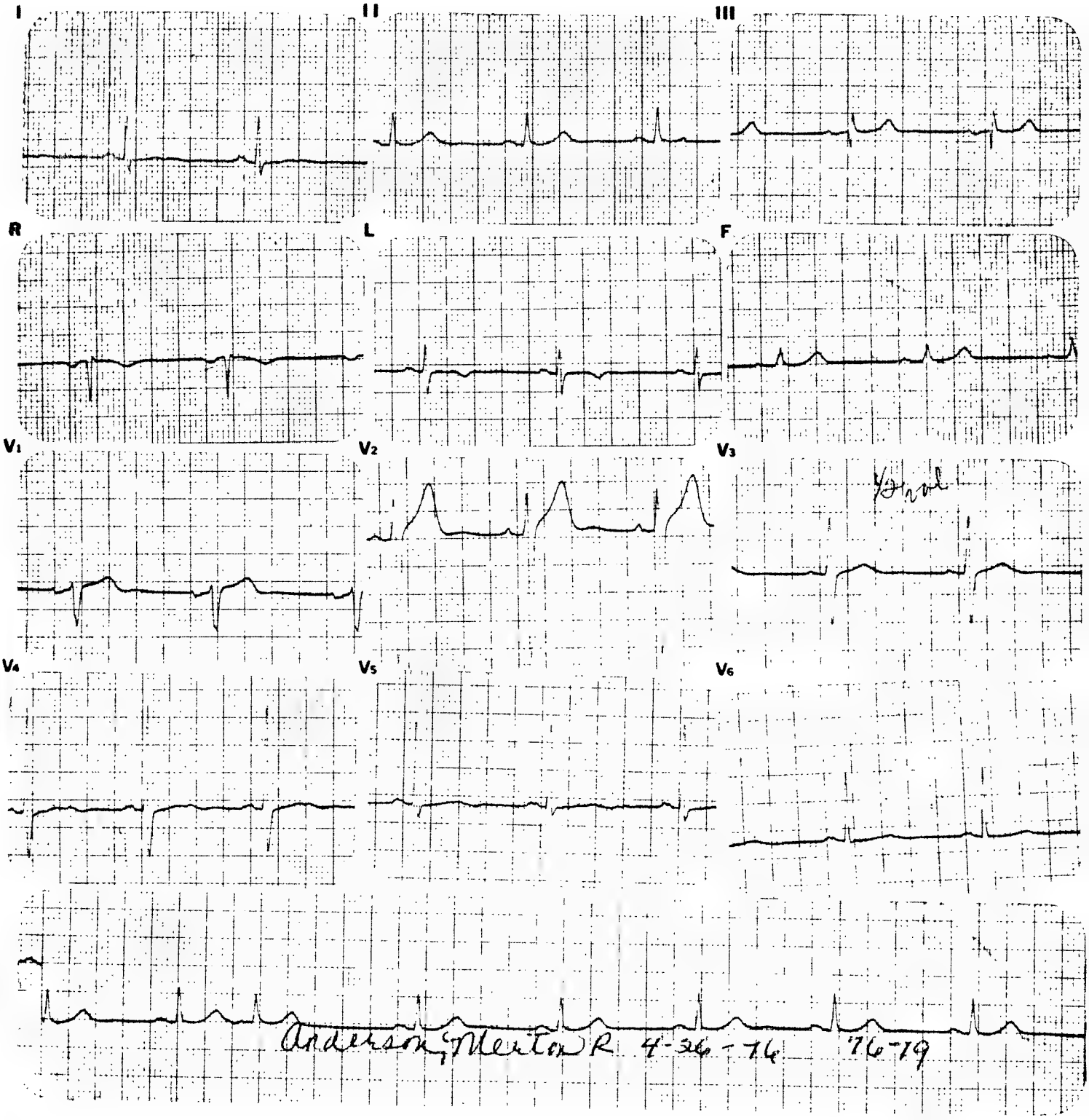
TYPED OR PRINTED NAME OF PHYSICIAN OR	DATE	NUMBER OF ATTACHED SHEETS
	3/31/75	

b6
b7C

REVERSE OF STANDARD FORM 93

GPO: 1972 O-463-911

ANDERSON MERTON R
F
7 11 20 M



APR 26 19

CLIN DIAG

ECG DESCRIPTION:

INTERPRETATION:

DIG. ( ) QUIN. ( ) AGE 55 SE b6 Nal B P
b7C

ECG REQUEST BY

ATR. RATE 64 VENTR RATE

INTERVALS: P-R .16 QRS .08 QTc

AXIS +45°

RHYTHM NSR

INTERPRETED BY

5-19

PATIENT
ANDERSON MERTON R

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101–11.8

Approved
Office of Management and Budget No. 29–R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
ANDERSON, MERTON R.	393 05 3331
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*	**4. POSITION** *(City, grade, component)*
11000 Wilshire Boulevard Los Angeles, California	SPECIAL AGENT

5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
ANNUAL PHYSICAL	4/26/76	U. S. PUBLIC HEALTH San Pedro, California

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

Good

9. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever, erysipelas		✓		Cramps in your legs		✓		"Trick" or locked knee
	✓		Rheumatic fever		✓		Frequent indigestion		✓		Foot trouble
	✓		Swollen or painful joints		✓		Stomach, liver, or intestinal trouble		✓		Neuritis
	✓		Frequent or severe headache		✓		Gall bladder trouble or gallstones		✓		Paralysis (include infantile)
	✓		Dizziness or fainting spells		✓		Jaundice or hepatitis		✓		Epilepsy or fits
	✓		Eye trouble				Adverse reaction to serum, drug,		✓		Car, train, sea or air sickness
✓			Ear, nose, or throat trouble		✓		or medicine		✓		Frequent trouble sleeping
	✓		Hearing loss		✓		Broken bones		✓		Depression or excessive worry
	✓		Chronic or frequent colds		✓		Tumor, growth, cyst, cancer		✓		Loss of memory or amnesia
	✓		Severe tooth or gum trouble		✓		Rupture/hernia		✓		Nervous trouble of any sort
	✓		Sinusitis		✓		Piles or rectal disease		✓		Periods of unconsciousness
	✓		Hay Fever		✓		Frequent or painful urination				
	✓		Head injury		✓		Bed wetting since age 12				
	✓		Skin diseases		✓		Kidney stone or blood in urine				
	✓		Thyroid trouble		✓		Sugar or albumin in urine				
	✓		Tuberculosis		✓		VD—Syphilis, gonorrhea, etc.				
	✓		Asthma		✓		Recent gain or loss of weight				
	✓		Shortness of breath		✓		Arthritis, Rheumatism, or Bursitis				
	✓		Pain or pressure in chest		✓		Bone, joint or other deformity				
	✓		Chronic cough		✓		Lameness				
	✓		Palpitation or pounding heart		✓		Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
	✓		Heart trouble		✓		Painful or "trick" shoulder or elbow				Been treated for a female disorder
	✓		High or low blood pressure		✓		Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*

✓ Right handed ☐ b6 b7C anded

93–101

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	✓	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
	✓	B. Inability to perform certain motions.
	✓	C. Inability to assume certain positions.
	✓	D. Other medical reasons (*If yes, give reasons.*)
	✓	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details).*
	✓	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
✓		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
✓		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
	✓	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
	✓	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
	✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
	✓	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)
	✓	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

See below
Tonsilectomy - Hondo AFB, Hondo, Texas - Jan 1943 - Dr Unknown age 22 yrs.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

HC as above

b6
b7C

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ADDITIONAL SHEETS
	4 Nov 43		

REVERSE OF STANDARD FORM 88

GPO:1971—O-422-099

7619
ANDERSON HERTON R
PS P
7 31 00 M

PATIENT _____ DATE 3-31-75

ADDRESS _____ AGE 54 SEX Male

_____ HEIGHT _____ WEIGHT _____

TELEPHONE NO. _____ BUILD { LINEAR _____ INTERMEDIATE _____ LATERAL _____

OCCUPATION _____ BLOOD PRESSURE _____

DOCTOR(S) [redacted] b6 b7C

HISTORY _____

MEDICATION _____

PATIENT POS. _____ P WAVES _____

AURIC. RATE _____ T WAVES _____

VENT. RATE 60 S-T SEGMENT _____

P-R INTERVAL 0.16 RHYTHM _____

QRS INTERVAL 0.08 ELEC. AXIS _____

Q-T INTERVAL 0.36 ELEC. POSITION _____

~~Doctor~~

FINDINGS Minor non specific ST-T wave changes
Normal sinus rhythm

REMARKS _____ DATE 3/31/75

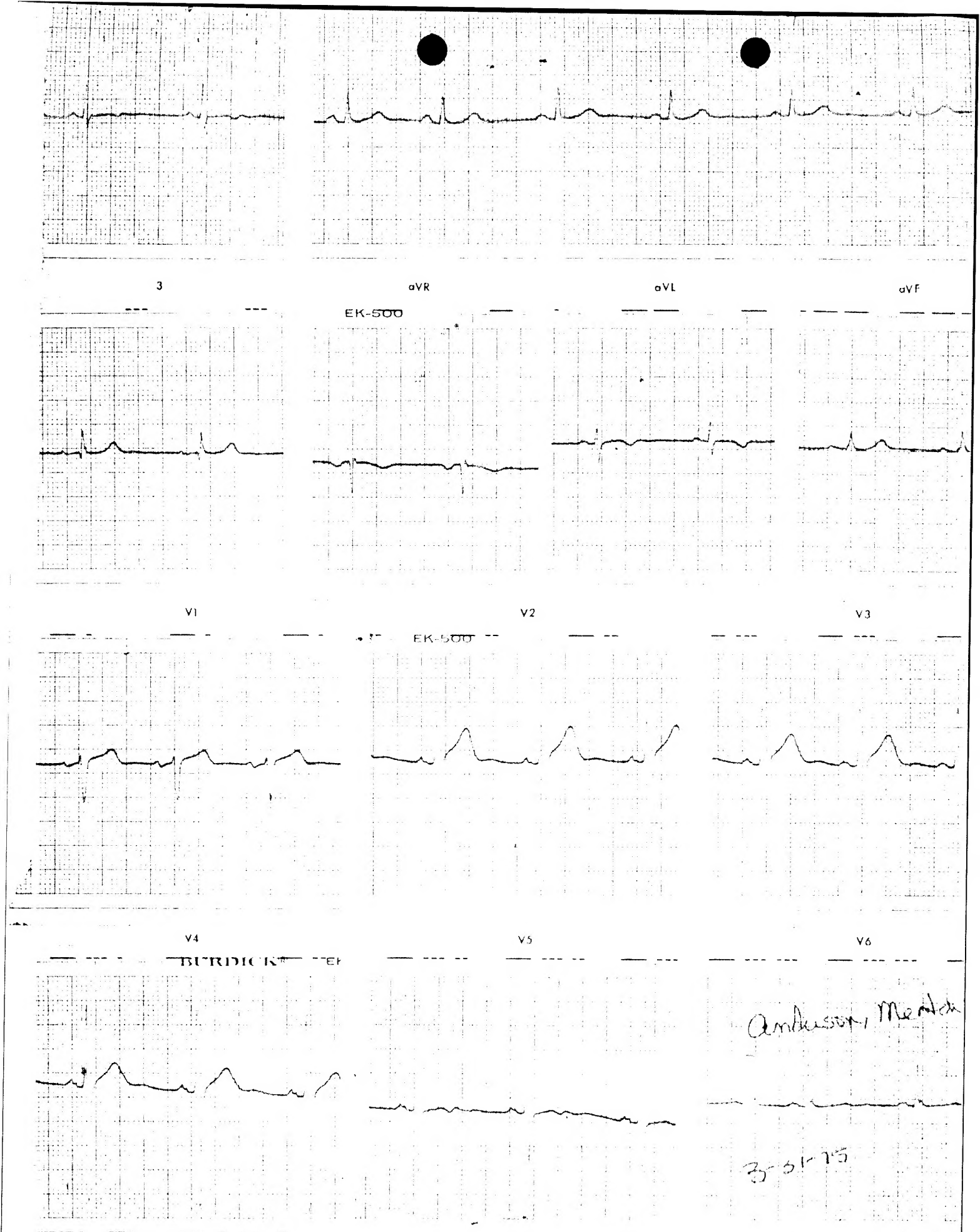
27

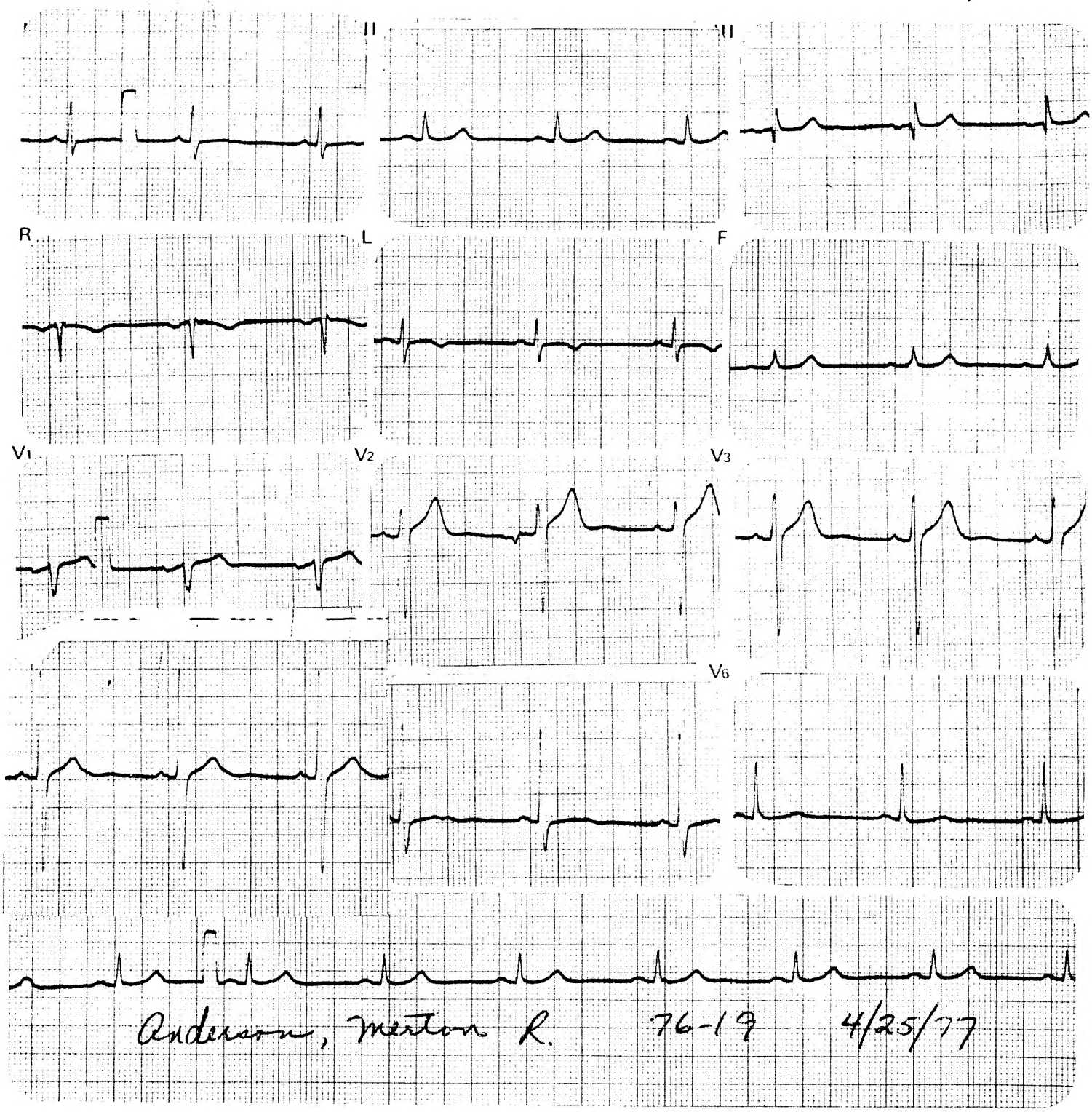
PATIENT

ECG NO.

CASE NO.

DATE


3
aVR
aVL
aVF
EK-500
V1
V2
V3
EK-500
V4
V5
V6
Admission Meds
3-31-75



N. DIAG:

DESCRIPTION: Since 4-26-76, NSST Ø persist.

ERPRETATION: No real Ø. Treadmill is probably

7 6 1 9

DIG. ( ) QUIN. ( ) AGE 56 SEX M B.P.

EGG REQUEST BY [redacted] 4-25 b6 b7c

ATR. RATE ____ VENTR. RATE ____

INTERVALS: P-R 14 QRS 06 QTc ____

AXIS: +60

RHYTHM: Sinus

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101-11.8

Approved
Office of Management and Budget No. 29-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
ANDERSON, MERTON R.	393 05 3331
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*	**4. POSITION** *(Title, grade, component)*
11000 Wilshire Boulevard Los Angeles, California	SPECIAL AGENT

5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
ANNUAL PHYSICAL	4/25/77	U. S. PUBLIC HEALTH San Pedro, California

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	*(Check each item)*
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
	✓		Scarlet fever, erysipelas		✓		Cramps in your legs		✓		"Trick" or locked knee
	✓		Rheumatic fever		✓		Frequent indigestion		✓		Foot trouble
	✓		Swollen or painful joints		✓		Stomach, liver, or intestinal trouble		✓		Neuritis
	✓		Frequent or severe headache		✓		Gall bladder trouble or gallstones		✓		Paralysis (include infantile)
	✓		Dizziness or fainting spells		✓		Jaundice or hepatitis		✓		Epilepsy or fits
	✓		Eye trouble				Adverse reaction to serum, drug,		✓		Car, train, sea or air sickness
✓			Ear, nose, or throat trouble		✓		or medicine		✓		Frequent trouble sleeping
	✓		Hearing loss		✓		Broken bones		✓		Depression or excessive worry
	✓		Chronic or frequent colds		✓		Tumor, growth, cyst, cancer		✓		Loss of memory or amnesia
	✓		Severe tooth or gum trouble		✓		Rupture/hernia		✓		Nervous trouble of any sort
	✓		Sinusitis		✓		Piles or rectal disease		✓		Periods of unconsciousness
	✓		Hay Fever		✓		Frequent or painful urination		✓		
	✓		Head injury		✓		Bed wetting since age 12				
	✓		Skin diseases		✓		Kidney stone or blood in urine				
	✓		Thyroid trouble		✓		Sugar or albumin in urine				
	✓		Tuberculosis		✓		VD—Syphilis, gonorrhea, etc.				
	✓		Asthma		✓		Recent gain or loss of weight				
	✓		Shortness of breath		✓		Arthritis, Rheumatism, or Bursitis				
	✓		Pain or pressure in chest		✓		Bone, joint or other deformity				
	✓		Chronic cough		✓		Lameness				
	✓		Palpitation or pounding heart		✓		Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
	✓		Heart trouble		✓		Painful or "trick" shoulder or elbow				Been treated for a female disorder
	✓		High or low blood pressure		✓		Recurrent back pain				Had a change in menstrual pattern
											b6
											b7C

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*

☑ Right handed ☐ Left handed

93-101

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	✓	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
	✓	B. Inability to perform certain motions.
	✓	C. Inability to assume certain positions.
	✓	D. Other medical reasons (*If yes, give reasons.*)
	✓	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details).*
	✓	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
✓		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
✓		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
	✓	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
	✓	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
	✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
	✓	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)
	✓	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

Tonsilectomy - Hondo AFB, Hondo, Texas - Jan 9, 1943 - Dr Unknown - Age 22

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
MERTON R. ANDERSON	Merton R. Anderson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

VIOLETA ACERO, M.D. for

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIG	NUME ATTA
for			HEETS

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